

11299 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5/29/54	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 852 Maryland Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle W. Last Aberle		4. DATE OF DEATH Month November Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Parker		14. MOTHER'S MAIDEN NAME Verlinda M. Lingo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Senile Degeneration		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Degeneration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/29/54 , 19____, to 11/1/57 , 19____, that I last saw the deceased alive on 11/1/57 , 19____, and that death occurred at 3:50 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. J. E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/2/57	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1957	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer,		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR 11/5/57		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry or prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased John W. Barker		Age 40		Sex Male		Race White		Color White		Date of Birth 7/23/1874		Date of Death 11/1/1917		Place of Birth U.S.A.	
Residence Baltimore, Maryland		Usual Place of Abode Baltimore, Maryland		Cause of Death Heart Disease		Manner of Death Natural		Occupation None		Education None		Religion None		Marital Status Single	
Signature of Physician John W. Barker		Signature of Coroner John W. Barker		Signature of Registrar John W. Barker		Signature of Burial Officer John W. Barker		Signature of Undertaker John W. Barker		Signature of Witness John W. Barker		Signature of Witness John W. Barker		Signature of Witness John W. Barker	
Name of Burial Place U.S.A.		Name of Burial Place U.S.A.		Name of Burial Place U.S.A.		Name of Burial Place U.S.A.		Name of Burial Place U.S.A.		Name of Burial Place U.S.A.		Name of Burial Place U.S.A.		Name of Burial Place U.S.A.	

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NOV 6 1917

RECEIVED

11300 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN IB 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS 323 Baltimore Ave.			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lucilla Middle Aiello Last Aiello				4. DATE OF DEATH Month November Day 3 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/08	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE Ret.				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) West Virginia, Keyser	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William E. Lewis				14. MOTHER'S MAIDEN NAME Mary Coffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-07-6186		17. INFORMANT patients chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA CERVIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 171X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 MOS.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from APRIL , 19 57 , to NOV , 19 57 , that I last saw the deceased alive on NOV. 2 , 19 57 , and that death occurred at 1:25A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Cawley M.D.				ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED Nov. 5/57			
PHYSICIAN'S NAME (Type) Frank T. Cawley, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Beaver Run Cemetery		22d. LOCATION (City, town, or county) (State) Beaver Run, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Nov. 7, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

11301

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 5 DAYS		d. STREET ADDRESS 29 VIRGINIA AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL, HOSPITAL, MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MRS. GLADYS Middle BAKER Last		4. DATE OF DEATH Month NOV. Day 24 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30 July 20, 1903
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife and		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Assembly Line work (during war) WILLIAM KENNEDY		14. MOTHER'S MAIDEN NAME ADA HARTMAN HARTLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-4018	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cerebral Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 56 to Nov , 19 57 , that I last saw the deceased alive on Nov 24 , 19 57 , and that death occurred at 6:30PM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md. DATE SIGNED 11/25/57 ACTUAL SIGNATURE G. O. HIMMELWRIGHT, M.D. PHYSICIAN'S NAME (Type) G. O. HIMMELWRIGHT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 27, 1957	22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	22d. LOCATION (City, town, or county) (State) Hyndman, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR 11/26/1957	24b. REGISTRAR'S SIGNATURE John Van Strien, M.D.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED

11302 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 36 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. STREET ADDRESS ROUTE NO. 1			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle OSCAR Last BANE				4. DATE OF DEATH Month NOVEMBER Day 10 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 16 1885	
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bldg. Inspector.				10b. KIND OF BUSINESS OR INDUSTRY Western Md. R. R.			
11. BIRTHPLACE (State or foreign country) LOARTOWN, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME HARRIS HOLLAND BANE				14. MOTHER'S MAIDEN NAME REBECCA LOAR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. William Bane, Rt. # 1, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Asymia - Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Generalized arteriosclerosis (c) Diabetes mellitus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug , 19 55 , to 11/10 , 19 57 , that I last saw the deceased alive on 11/10 , 19 57 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE GEORGE SIMONS M.D. 128 Union St 11/10/57 PHYSICIAN'S NAME (Type) George M. Simons Cumberland, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bedford Valley, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Nov. 12, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register or prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM WILLIAM LANE		AGE 36		SEX MALE		RACE WHITE		DATE OF BIRTH JANUARY 10 1921		PLACE OF BIRTH BALTIMORE, MARYLAND	
DATE OF DEATH NOVEMBER 10 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL		OCCUPATION LABORER	
NAME OF PHYSICIAN DR. J. J. GEORGE		NAME OF HOSPITAL HOSPITAL		NAME OF NURSE NURSE		NAME OF ASSISTANT ASSISTANT		NAME OF ATTENDING ATTENDING		NAME OF CORONER CORONER	
NAME OF FUNERAL HOME FUNERAL HOME		NAME OF BURIAL PLACE BURIAL PLACE		NAME OF CEMETERY CEMETERY		NAME OF INTERMENT INTERMENT		NAME OF CREMATION CREMATION		NAME OF OTHER OTHER	

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NOV 18 1957

RECEIVED

CERTIFICATE OF DEATH

11394

11366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 R.F.D. #1, Vale Summit</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>127 Centre St.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bechie</u> Last <u>Bechie</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Miner</u>	
11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John Bechie, Jr.</u>		Address <u>Vale Summit Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastro Enteritis</u> DUE TO <u>571.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Semility & arterio sclerosis</u> DUE TO (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 6</u> , 1957, to <u>Nov 8</u> , 1957, that I last saw the deceased alive on <u>Nov 8</u> , 1957, and that death occurred at <u>6:50 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W O Mc Lane</u>		ADDRESS (Street, city or town, state) <u>1502 Bragg</u>	
PHYSICIAN'S NAME (Type) <u>W O Mc Lane</u>		DATE SIGNED <u>Nov 10 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 11, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Montesant</u>		24a. REC'D BY REGISTRAR <u>DATE 11-11-57</u>	
ADDRESS <u>Water Funeral Home 23 E. Main Frostburg Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Stanley H. Ritz</u>	

NOV 15 1957

RECEIVED

DR. W.F. WILLIAMS

11303

CERTIFICATE OF DEATH

Reg. Dist. No.

11385

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 17 VIRGINIA AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHERINE Middle ELISHA Last BLAIR		4. DATE OF DEATH Month NOVEMBER Day 4 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 23 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife also did Domestic work		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND Frostburg	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID STODDART		14. MOTHER'S MAIDEN NAME STELLA THOMAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 373-16-8538	
17. INFORMANT Mrs. Nell Windermuth Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Duodenum Sec 1 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Several Debility for over a long period of time		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1-57 , to 11-4-57 , that I last saw the deceased alive on 11-3-57 , 19 57 , and that death occurred at 1:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.F. Williams		ADDRESS (Street, city or town, state) Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		DATE SIGNED 11-4-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-57	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Cem		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 11/6/1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2012-11-14 14:44:20

YALOW, J. M.

CONCLUSION

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BUREAU V. 3

NOV 7 1957

RECEIVED

11346

Reg. Dist. No.

~~11304~~

1. PLACE OF DEATH a. COUNTY		1904		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany		MARYLAND		a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cumberland		45 yrs		02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		417 Fayette Street		d. STREET ADDRESS 417 Fayette Street	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH Month Day Year	
JOHN HENRY BOETTNER				November 2, 1957 19	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Oct. 7, 1874		83 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Engineer		Alleg. High School		Frostburg, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry M. Boettner		Liza J. Grady		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Mrs. Mary E. Boettner	
				417 Fayette Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic myocardiitis		2 years	
422.1 DUE TO		Arteriosclerosis		4 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Aug 4, 1956, to Nov 2, 1957, that I last saw the deceased alive on Nov 1st, 1957, and that death occurred at 6:51 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE R. W. Trvaskis, Jr		M.D. Cumberland, Maryland		Nov. 4, 1957	
PHYSICIAN'S NAME (Type)		R. W. Trvaskis M.D.		220 Baltimore Avenue, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		Nov. 5, 1957		Hillcrest Burial Park	
22d. LOCATION (City, town, or county) (State)		Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
John J. Hafer, Cumberland, Maryland				Date 11-5-1957 W. Ross Cameron, M.D.	

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11305

CERTIFICATE OF DEATH

Reg. Dist. No.

11317

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last BRANNON		4. DATE OF DEATH Month NOVEMBER Day 26 , Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 22, 1957
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY A. BRANNON		14. MOTHER'S MAIDEN NAME MARY T. WEIMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HENRY BRANNON,		Address MT. SAVAGE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.3 Congenital Heart DUE TO (b) Patent Ductus Arteriosus DUE TO (c) Patent Foramen Ovale			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 22 Nov, 1957 , to 26 Nov, 1957 , that I last saw the deceased alive on 11 Nov, 1957 , and that death occurred at 2:55 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Fuller B. Whitworth M.D.		ADDRESS (Street, city or town, state) 23 Bedford DATE SIGNED 26 Nov 57	
PHYSICIAN'S NAME (Type or print) DR. FULLER B. WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-27-57	22c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	22d. LOCATION (City, town, or county) (State) Bedford Road, Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR Nov 27, 1957	24b. REGISTRAR'S SIGNATURE Paul van Stien, M.D.

1 Within corporate limits.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

NOV 28 1951

RECEIVED

Within corporate limits

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1318

11306 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE PENNSYLVANIA COUNTY Bedford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 37 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle M. Last BRANT				4. DATE OF DEATH Month NOVEMBER Day 18 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 29, 1905	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY B&O Trackman		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME FRANK BRANT				MOTHER'S MAIDEN NAME EMMA BOWMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 705-07-9416		17. INFORMANT Pauline Bryant Brant, Hyndman, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1957 to 7/10/18 , 19 57 , that I last saw the deceased alive on 7/10/18 , 19 57 , and that death occurred at 3:14 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyndman, Pa. DATE SIGNED 11/19/57							
ACTUAL SIGNATURE John A. Topper				M.D. Hyndman, Pa.			
PHYSICIAN'S NAME (Type) DR. J. TOPPER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence L. Long, Jr.				ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE 11/21/57	
				24b. REGISTRAR'S SIGNATURE Jon van Stuen, M.D.			

With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11319

11307

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 1 209 EMILY STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELSIE Middle ETTA Last BRASHEARS		4. DATE OF DEATH Month NOVEMBER Day 16 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaners	
11. BIRTHPLACE (State or foreign country) DAVIS, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC BRASHEARS		14. MOTHER'S MAIDEN NAME IVA BUCY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Infantile of the Left lobe of the brain DUE TO Central hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 12 hours DUE TO 12 hours (c) 12 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15, 1957 , to Nov 16, 1957 , that I last saw the deceased alive on Nov 15, 1957 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Al Weisman M.D.		ADDRESS (Street, city or town, state) 598 Greene St DATE SIGNED 11/18/57	
PHYSICIAN'S NAME (Type) DR. WEISMAN		Cumberland, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/18/57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Hafer		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 11/19/1957		24b. REGISTRAR'S SIGNATURE John van Strien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

YANG ET AL.

1971-1972

TESTE YOURSELF

2000

178 JOURNAL OF DOCUMENTATION

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BUREAU V. S.

NOV 26 1951

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

11367

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LLOYD F. BROADWATER		4. DATE OF DEATH NOV. 9 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-75
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) TARRETT, Co. MD		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Amos Broadwater		14. MOTHER'S MAIDEN NAME Bittinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 111-11-1111	
17. INFORMANT H. Johnson		Address Berlin, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular Renal Disease (c) Benign Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 1 yr years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1956 to Nov 9, 1957 , that I last saw the deceased alive on Nov 9, 1957 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 23 Broadway, Frostburg, Pa. 1957	
PHYSICIAN'S NAME (Type) John B. Davis, M.D.		DATE SIGNED Nov 12-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-12-57	22c. NAME OF CEMETERY OR CREMATORY Ridge Church Cemetery	22d. LOCATION (City, town, or county) (State) Berlin, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE H. Johnson		24a. RECEIVED BY REGISTRAR Nov 12-57	
ADDRESS Berlin, Pa.		24b. REGISTRAR'S SIGNATURE Mrs. Mary H. Rose	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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CERTIFICATE OF DEATH

Page 1 of 1

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is mostly blank with some faint, illegible handwriting.

15:15 Road 27

John B. Davis, Jr.
Baltimore, Md.

John B. Davis, Jr.
Baltimore, Md.

NOV 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

With corporate seal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11308 Item 9 Film G223 12-2-57 et
CERTIFICATE OF DEATH

11321
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Olympia Hotel Baltimore Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Martin Middle Luther Last Burch				4. DATE OF DEATH Month Nov. Day 23 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29 1905	
9. AGE (In years last birthday) 52 3/4		IF UNDER 1 YEAR Months 0 Days 23 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 23 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Factory Worker				10b. KIND OF BUSINESS OR INDUSTRY Fairchild's Aircraft			
11. BIRTHPLACE (State or foreign country) Cumberland Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Elbert C. Burch				14. MOTHER'S MAIDEN NAME Betty Holtzman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 214-05-6657		17. INFORMANT Sacred Heart Hosp. Cumb Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease DUE TO (c) Chronic bronchitis and neurogenic bladder				INTERVAL BETWEEN ONSET AND DEATH 3 years 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis and neurogenic bladder				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 0				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumb Md.				20g. (County) Cumb Md.		20h. (State) Md.	
21. I certify that I attended the deceased from Oct 6 1957 to Nov 23 1957 , that I last saw the deceased alive on Nov 22 1957 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. W. Trevas, Sr. M.D. Cumberland, Md.				DATE SIGNED 11/23/57			
PHYSICIAN'S NAME (Type) R. W. TREVAS, SR.				ADDRESS Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumb Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Allen Inc.				ADDRESS Cumb Md.		24a. REC'D BY REGISTRAR Nov. 25, 1957	
24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.							

RECEIVED

Within 1 hour after death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11322

11309

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 31 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at the Memorial Hospital				d. STREET ADDRESS 1441 Goethe St.			
3. NAME OF DECEASED (Type or print) First Mary Middle M. R. Last Cannon				4. DATE OF DEATH Month Nov. Day 18 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27-1884		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household duties		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Martinsburg, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Burton				14. MOTHER'S MAIDEN NAME Mary Margaret Murman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address (niece) Margaret Barnard, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) (c) [a], stating the underlying cause lost. DUE TO 						INTERVAL BETWEEN ONSET AND DEATH sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE H. V. Deming M.D. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 18-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Cumberland, Maryland.				24a. REC'D BY REGISTRAR Nov. 19, 1957		24b. REGISTRAR'S SIGNATURE Don van Stuen, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 20 1957

BUREAU V. S.

RECEIVED
NOV 20 1957
BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF THE MEDICAL EXAMINER: [illegible]

11368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>4 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>M.</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16.</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Connor</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ann Mathews</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Esther Carter, Eckhart, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO <u>Rt. Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 Days</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 21</u> , 19 <u>57</u> , to <u>Nov 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>57</u> , and that death occurred at <u>5:00 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WOM Lane</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>Nov 18 1957</u>	
PHYSICIAN'S NAME (Type) <u>WOM Lane MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u> ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-18-57</u> 24b. REGISTRAR'S SIGNATURE <u>Miss Nancy N. Poe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

File No.

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. COLOR OF EYES [Faint text]		9. COLOR OF HAIR [Faint text]		10. COLOR OF SKIN [Faint text]	
11. CAUSE OF DEATH [Faint text]		12. MANNER OF DEATH [Faint text]		13. PLACE OF DEATH [Faint text]		14. DATE OF DEATH [Faint text]		15. TIME OF DEATH [Faint text]	
16. SIGNATURE OF PHYSICIAN [Faint text]		17. SIGNATURE OF REGISTRAR [Faint text]		18. SIGNATURE OF WITNESS [Faint text]		19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF NEXT OF KIN [Faint text]	

BUREAU V. 5

NOV 25 1957

RECEIVED

CERTIFICATE OF DEATH

11324

Reg. Dist. No.

11310

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 446 Williams Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Belle Collins		4. DATE OF DEATH Month November Day 3 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1862
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Buffalo Mills, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Carpenter		14. MOTHER'S MAIDEN NAME Ida May Carpenter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Russell Collins		Address 446 Williams Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 wks 5 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1957 to Nov 3, 1957 , that I last saw the deceased alive on Sept 15, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		DATE SIGNED 11/5/57	
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D. 221 Virginia Ave., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 6, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) Bedford County, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Nov 7, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. THE 15

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF NOTARY		SIGNATURE OF SHERIFF	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE CITY CLERK	

BUREAU V. 8

NOV 8 1957

RECEIVED

11325

11384 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown Md.</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>1 Oldtown Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oldtown Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Conley</u> Last <u>Conley</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>I</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Oldtown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rudolph Luterman</u>		14. MOTHER'S MAIDEN NAME <u>Eveline Twigg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Evelyn Myers by Greenspring, W.V.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicaemia (from bedsores)</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis and myocarditis</u> DUE TO (c) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u> <u>10-20 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>—</u> , to <u>Oct. 25, 1957</u> , that I last saw the deceased alive on <u>9-25-57</u> , 19 <u>—</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Paw Paw, W. Va.</u> DATE SIGNED <u>10-1-57.</u>			
ACTUAL SIGNATURE <u>J. I. Armstrong</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. I. Armstrong.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov 3 1957</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Oldtown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oldtown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Steinbo</u> ADDRESS <u>Cumberland Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 5, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. Jay Duckworth</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11327

NAME OF DECEASED: *John Doe*

DATE OF DEATH: *Nov 8 1952*

PLACE OF DEATH: *Home*

AGE: *65*

SEX: *Male*

RACE: *White*

EDUCATION: *High School*

OCCUPATION: *Teacher*

CAUSE OF DEATH: *Heart Disease*

IMMEDIATE CAUSE: *Myocardial Infarction*

UNDERLYING CAUSE: *Coronary Artery Disease*

DATE OF BIRTH: *Nov 15 1887*

PLACE OF BIRTH: *Baltimore, Md.*

DATE OF DEATH: *Nov 8 1952*

PLACE OF DEATH: *Home*

AGE: *65*

SEX: *Male*

RACE: *White*

EDUCATION: *High School*

OCCUPATION: *Teacher*

CAUSE OF DEATH: *Heart Disease*

IMMEDIATE CAUSE: *Myocardial Infarction*

UNDERLYING CAUSE: *Coronary Artery Disease*

DATE OF BIRTH: *Nov 15 1887*

PLACE OF BIRTH: *Baltimore, Md.*

BUREAU V. S.

NOV 8 1952

RECEIVED

11311

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 13 DAYS							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 325 AVIRETT AVE.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ELDRIDGE Middle AUSTIN Last COOK		4. DATE OF DEATH		Month NOVEMBER Day 13 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17, 1897		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber Inspector		10b. KIND OF BUSINESS OR INDUSTRY B & O.		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME TED W. COOK				14. MOTHER'S MAIDEN NAME KATTIE GRUBER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no.		16. SOCIAL SECURITY NO. — (If yes, give war or dates of service)		17. INFORMANT Memorial Hospital Address Cumb. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Fibrosis, Coronary Arteriosclerosis DUE TO left bundle branch Block (c) Left Ventricular Hypertrophy, Bronchial Asthma							INTERVAL BETWEEN ONSET AND DEATH 44 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Jaundice Uremia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1, 1957 , to November 13, 1957 , that I last saw the deceased alive on November 13, 1957 , and that death occurred at 12:18 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 11/14/57							
ACTUAL SIGNATURE Samuel Jacobson M.D.				CUMBERLAND, MARYLAND			
PHYSICIAN'S NAME (Type) SAMUEL JACOBSON							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF 11/14/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumb. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb. Md				24a. REC'D BY REGISTRAR Nov 15, 1957		24b. REGISTRAR'S SIGNATURE Jordan Stein, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate may be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED HARRIS, JAMES		AGE 45		SEX MALE		RACE WHITE		DATE OF DEATH JAN 15 1957	
PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		COUNTRY UNITED STATES	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		MEDICAL OPINION NO SIGN OF FORCE	
DATE OF BIRTH JAN 1 1912		PLACE OF BIRTH BALTIMORE		CITY OF BIRTH BALTIMORE		COUNTY OF BIRTH BALTIMORE		STATE OF BIRTH MARYLAND	
MOTHER'S NAME JANE HARRIS		FATHER'S NAME JOHN HARRIS		MARRIAGE DATE JUN 15 1935		MARRIAGE PLACE BALTIMORE		MARRIAGE STATE MARYLAND	
EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARITAL STATUS MARRIED		PREVIOUS MARRIAGES NONE		PREVIOUS DEATHS NONE	
DATE OF INTERVIEW JAN 16 1957		INTERVIEWER DR. J. H. SMITH		SIGNATURE OF DECEASED JAMES HARRIS		SIGNATURE OF WITNESS JOHN HARRIS		SIGNATURE OF PHYSICIAN DR. J. H. SMITH	

BUREAU V. S.

NOV 18 1957

RECEIVED

11312

CERTIFICATE OF DEATH

11327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carl Middle Elisha Last Cooke				4. DATE OF DEATH Month 11 Day 24 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/26/97	
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Cooke				14. MOTHER'S MAIDEN NAME Elizabeth Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-7283		17. INFORMANT Patient's chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary abscesses and paralytic ileus DUE TO Infection and operation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 14 days (c) 14 days							INTERVAL BETWEEN ONSET AND DEATH 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lipoma large pelvis & obstruction of ureters & A							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 8 , 1957, to Nov 24 , 1957, that I last saw the deceased alive on Nov 24 , 1957, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 232 Baltimore Ave DATE SIGNED Nov 25, 1957							
ACTUAL SIGNATURE Carlton Brinsfield				M.D. 232 Baltimore Ave			
PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD				Cumulated m.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/57		22c. NAME OF CEMETERY OR CREMATORY Sylabayer Luth Cem		22d. LOCATION (City, town, or county) (State) Madley Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Louis & Son Inc.				ADDRESS Cum. M. D.		24a. REC'D BY REGISTRAR Nov 26, 1957	
				24b. REGISTRAR'S SIGNATURE Jan van Strien, M.D.			

MEDICAL CERTIFICATION

2

62

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 27 1957

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body of a copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11328

11385 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MD.</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>LUKE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>LUKE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PRATT ST.</u>				STREET ADDRESS (If rural give location) <u>PRATT ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>ANNA L. CRUMP</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 20 19 57</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>AUG. 7, 18, 1889</u>	
9. AGE last birthday <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANIEL LAUGHLIN</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN CAREY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MILTON CRUMP, LUKE, MD.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
415X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)				<u>chronic Myocarditis and Myocardial Degeneration specified as Rheumatic</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arthritis Deformans</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 Years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. or P.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 15 19 57</u>, to <u>Nov. 20 19 57</u>, that I last saw the deceased alive on <u>Nov. 20 19 57</u>, and that death occurred at <u>11:10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Paul R. Wilson</u>				ADDRESS (Street, city, town, state) <u>Piedmont W. Va</u>			
DATE THEREOF <u>NOV. 23 1957</u>				DATE SIGNED <u>Nov. 22, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WESTERNPORT, MD.</u>			
24. REC'D BY REGISTRAR DATE <u>NOV 25 57</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

1957

Reg. File No.

LOCAL RESIDENT OR NOT

DATE OF DEATH

PLACE OF DEATH

DEATH ST.

DEATH ST.

CRIME

L. A.

MA

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BALTIMORE

BALTIMORE

BALTIMORE

DEATH ST.

DEATH ST.

DEATH ST.

CRIME

CRIME

CRIME

BUREAU V. 3

NOV 25 1957

RECEIVED

11313 CERTIFICATE OF DEATH

11329

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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MEDICAL CERTIFICATION

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 131 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO MIDLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HUGH Middle JOSEPH Last CUNNINGHAM				4. DATE OF DEATH Month NOVEMBER Day 15 Year 19 57.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 10, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) LONA CONING, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN CUNNINGHAM				14. MOTHER'S MAIDEN NAME MARY MURPHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEMORIA L HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac Failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive and arteriosclerotic DUE TO (c) Cardio - vascular Disease INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis with asthma							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9:30 AM , 19 57 , to 15 Nov , 19 57 , that I last saw the deceased alive on 15 Nov , 19 57 , and that death occurred at 7:00P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer				ADDRESS (Street, city or town, state) 122 S. Centre St. DATE SIGNED 15 Nov 57			
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Maryland.				24a. REC'D BY REGISTRAR Nov 18, 1957 24b. REGISTRAR'S SIGNATURE Don van Strien, M.D.			

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11314

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11330

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O. at the Memorial Hospital</u>				d. STREET ADDRESS <u>1422 Virginia Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Carlton</u> Middle <u>R.</u> Last <u>Cuppett</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31-1921</u>	
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. of the Imperial Ice Cream Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Westernport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otis T. Cuppett</u>				14. MOTHER'S MAIDEN NAME <u>Iona May Kerns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-9112</u>		17. INFORMANT <u>(mother) Iona May Cuppett, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 581.0 DUE TO <u>Ruptured esophageal varcies</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute fatty liver</u> DUE TO <u>Edema, generalized.</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>gradual about 2 weeks</u> <u>? about 4 week</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 30-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oldtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oldtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>Dec. 1, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jon van Strien, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

11315

CERTIFICATE OF DEATH

11331

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 1, VALLEY RD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS 1 RT 1 Valley Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NERIE Middle I Last DICKEN		4. DATE OF DEATH Month NOVEMBER Day 27 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/93
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months 6 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY B + O.	
11. BIRTHPLACE (State or foreign country) Cumberland Valley Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NERI DICKEN		14. MOTHER'S MAIDEN NAME ALICE BRANT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) NO (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 220-10-5464	
17. INFORMANT WIFE LAVINA		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 16 years Bronchial Asthma - Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 57 , to 11-27 , 19 57 ; that I last saw the deceased alive on 11-27 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St DATE SIGNED 10/28/57			
ACTUAL SIGNATURE William P. James M.D.			
PHYSICIAN'S NAME (Type) William P. James		Cumberland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/30/57	22c. NAME OF CEMETERY OR CREMATORY Sunset Memo. Park	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR Nov. 29, 1957		24b. REGISTRAR'S SIGNATURE Jordan Steen, M.D.	

DEC 2 1957

RECEIVED

11316

CERTIFICATE OF DEATH

Reg. Dist. No. 11332

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 37 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MR. HENRY Levi DIEHL		4. DATE OF DEATH NOV. 3 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1877
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Repairman		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA, Friends Cove		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SOLOMAN DIEHL		14. MOTHER'S MAIDEN NAME JENNIE WHETSTONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 705-10-7277	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) Pneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493x			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2, 1957 , to Nov 3, 1957 , that I last saw the deceased alive on November 2, 1957 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1200 down st Cumberland, Md 11/5/57 DATE SIGNED ACTUAL SIGNATURE George M. Simons M.D. PHYSICIAN'S NAME (Type) George M. Simons M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/57	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24a. REC'D BY REGISTRAR Nov 7, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF BIRTH		2. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
3. DATE OF BIRTH		4. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
5. SEX		6. RACE	
MALE		WHITE	
7. OCCUPATION		8. CAUSE OF DEATH	
LABORER		HEART DISEASE	
9. PLACE OF BIRTH		10. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
11. DATE OF BIRTH		12. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
13. SEX		14. RACE	
MALE		WHITE	
15. OCCUPATION		16. CAUSE OF DEATH	
LABORER		HEART DISEASE	
17. PLACE OF BIRTH		18. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
19. DATE OF BIRTH		20. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
21. SEX		22. RACE	
MALE		WHITE	
23. OCCUPATION		24. CAUSE OF DEATH	
LABORER		HEART DISEASE	
25. PLACE OF BIRTH		26. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
27. DATE OF BIRTH		28. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
29. SEX		30. RACE	
MALE		WHITE	
31. OCCUPATION		32. CAUSE OF DEATH	
LABORER		HEART DISEASE	
33. PLACE OF BIRTH		34. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
35. DATE OF BIRTH		36. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
37. SEX		38. RACE	
MALE		WHITE	
39. OCCUPATION		40. CAUSE OF DEATH	
LABORER		HEART DISEASE	
41. PLACE OF BIRTH		42. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
43. DATE OF BIRTH		44. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
45. SEX		46. RACE	
MALE		WHITE	
47. OCCUPATION		48. CAUSE OF DEATH	
LABORER		HEART DISEASE	
49. PLACE OF BIRTH		50. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
51. DATE OF BIRTH		52. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
53. SEX		54. RACE	
MALE		WHITE	
55. OCCUPATION		56. CAUSE OF DEATH	
LABORER		HEART DISEASE	
57. PLACE OF BIRTH		58. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
59. DATE OF BIRTH		60. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
61. SEX		62. RACE	
MALE		WHITE	
63. OCCUPATION		64. CAUSE OF DEATH	
LABORER		HEART DISEASE	
65. PLACE OF BIRTH		66. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
67. DATE OF BIRTH		68. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
69. SEX		70. RACE	
MALE		WHITE	
71. OCCUPATION		72. CAUSE OF DEATH	
LABORER		HEART DISEASE	
73. PLACE OF BIRTH		74. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
75. DATE OF BIRTH		76. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
77. SEX		78. RACE	
MALE		WHITE	
79. OCCUPATION		80. CAUSE OF DEATH	
LABORER		HEART DISEASE	
81. PLACE OF BIRTH		82. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
83. DATE OF BIRTH		84. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
85. SEX		86. RACE	
MALE		WHITE	
87. OCCUPATION		88. CAUSE OF DEATH	
LABORER		HEART DISEASE	
89. PLACE OF BIRTH		90. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
91. DATE OF BIRTH		92. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
93. SEX		94. RACE	
MALE		WHITE	
95. OCCUPATION		96. CAUSE OF DEATH	
LABORER		HEART DISEASE	
97. PLACE OF BIRTH		98. PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
99. DATE OF BIRTH		100. DATE OF DEATH	
JAN 1 1900		JAN 1 1900	

BUREAU V. S.

NOV 8 1957

RECEIVED

Charles I. George, Governor, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11333

11369

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Walter Middle Duncan Last				4. DATE OF DEATH Month November Day 3 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Duncan				14. MOTHER'S MAIDEN NAME Jean Rankin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 713-01-5925		17. INFORMANT Richard Duncan		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ante-mortem & Cor Pulmonale 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart disease (c) Silicosis & Bronchial Asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4-5 years 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1957 to Nov 3, 1957 , that I last saw the deceased alive on Nov 4, 1957 , and that death occurred at 10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Dawes				ADDRESS (Street, city or town, state) 134 E Main Frostburg, Md.			
DATE SIGNED 11/5/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/57		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.			
24a. REC'D BY REGISTRAR DATE 11-7-57		24b. REGISTRAR'S SIGNATURE Miss Mary H. Rose					

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1957

Name of Deceased Robert Duncan		Sex Male		Date of Birth August 2, 1902		Place of Birth U.S.A.	
Manner of Death Heart Disease		Cause of Death Coronary Artery Disease		Immediate Cause of Death Myocardial Infarction		Underlying Cause of Death Coronary Artery Disease	
Date of Death November 12, 1957		Place of Death Home		Physician's Signature Dr. J. H. Smith		Registrar's Signature John Doe	
Age at Death 55		Sex Male		Date of Birth August 2, 1902		Place of Birth U.S.A.	
Manner of Death Heart Disease		Cause of Death Coronary Artery Disease		Immediate Cause of Death Myocardial Infarction		Underlying Cause of Death Coronary Artery Disease	
Date of Death November 12, 1957		Place of Death Home		Physician's Signature Dr. J. H. Smith		Registrar's Signature John Doe	

NOV 12 1957

BUREAU V. S.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation or reinterment.

VS. A15ME(5)
SM 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
11317 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 4									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>55 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 Race St.</u>					d. STREET ADDRESS <u>101 Race St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>John</u> Last <u>Eifert</u>					4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>19 57</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14-1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired-engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Geison, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Eifert</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Pail</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-12-3975</u>		17. INFORMANT Address <u>(wife) Amanda Eifert, Cumberland, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 23-1957</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Nov. 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>			22d. LOCATION (City, town, or county) (State) <u>near Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>					24a. REC'D BY REGISTRAR <u>Nov 25, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jon van Stien, M.D.</u>		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

NOV 27 1957

RECEIVED

11318

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Mt. Savage			
				f. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Mary Middle Elliott Last Elliott				4. DATE OF DEATH Month 11 / Day 4 Year 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/14/57 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Lynch				14. MOTHER'S MAIDEN NAME Sara Ellen Rizer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Patient's Chart. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Fibrosis DUE TO (c) Bronchial Asthma							INTERVAL BETWEEN ONSET AND DEATH about 2 h ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 4, 19 57 , to November 5, 19 57 , that I last saw the deceased alive on November 5, 19 57 , and that death occurred at 2:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 11/7/57							
ACTUAL SIGNATURE Samuel M. Jacobson, M.D.				PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				24a. REC'D BY REGISTRAR Nov 7, 1957			
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 8 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

11319

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle E. Last EVERSOLE				4. DATE OF DEATH Month NOVEMBER Day 6 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 10, 1882	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cherry, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW HARPER				14. MOTHER'S MAIDEN NAME MARY NORTHINGTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Charles Eversole, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Cholecystitis & Cholelithiasis DUE TO 3 weeks (c) Chronic Myocarditis DUE TO 3 yrs							INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 22, 19 57 to Nov. 6, 19 57 , that I last saw the deceased alive on Nov. 6, 19 57 , and that death occurred at 10:15 AM on the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 11/8/57							
ACTUAL SIGNATURE Clay Durrett M.D.				PHYSICIAN'S NAME (Type) CLAY DURRETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-57		22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		22d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR Nov 9, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 Within corporate limits

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

NOV 21 1961

RECEIVED

DR. BALLIN

11320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWARD Middle L. Last FISHER				4. DATE OF DEATH Month NOVEMBER Day 4 Year 1957			
5. SEX Male		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1896	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61		IF UNDER 24 HRS. Days 61 Hours 61 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Good Will Ind.		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN FISHER				14. MOTHER'S MAIDEN NAME MARY REEDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Mrs. Emma Fisher, Cumberland, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c) 420.1 DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pub	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-15 , 19 55 , to 11-4 , 19 57 , that I last saw the deceased alive on 11-4 (4) 1957 , and that death occurred at 11:59 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 11-5-57							
ACTUAL SIGNATURE R. W. Ballin				M.D. 62 Greene St.			
PHYSICIAN'S NAME (Type) DR. BALLIN				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hafer, Cumberland, Md.				24a. REC'D BY REGISTRAR Nov 7, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED ALBERT		AGE 10		SEX MALE		RACE WHITE		DATE OF DEATH 1957		PLACE OF DEATH HOSPITAL	
RESIDENCE 1000		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		DATE OF BIRTH 1947		PLACE OF BIRTH HOSPITAL	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		OTHER CAUSES NONE	
DATE OF DEATH 1957		TIME OF DEATH 11:00 AM		PLACE OF DEATH HOSPITAL		DATE OF BIRTH 1947		TIME OF BIRTH 11:00 AM		PLACE OF BIRTH HOSPITAL	
NAME OF DECEASED ALBERT		AGE 10		SEX MALE		RACE WHITE		DATE OF DEATH 1957		PLACE OF DEATH HOSPITAL	
RESIDENCE 1000		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		DATE OF BIRTH 1947		PLACE OF BIRTH HOSPITAL	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		OTHER CAUSES NONE	
DATE OF DEATH 1957		TIME OF DEATH 11:00 AM		PLACE OF DEATH HOSPITAL		DATE OF BIRTH 1947		TIME OF BIRTH 11:00 AM		PLACE OF BIRTH HOSPITAL	

BUREAU V. 3

NOV 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Willis corporate limits

11321

CERTIFICATE OF DEATH

11338
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 Glenn Street</u>				d. STREET ADDRESS <u>1 217 Glenn Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora Catherine Fleming</u>				4. DATE OF DEATH Month Day Year <u>Nov. 11 1957 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10 1872</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cum Home</u>		11. BIRTHPLACE (State or foreign country) <u>Terra Alta W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Welch</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Ward</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Thomas H. Fleming St Michael Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable carcinoma of cervix</u> DUE TO (c) <u>8</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2+ yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>4/12</u> 19 <u>57</u> , to <u>11/11</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11/9</u> 19 <u>57</u> , and that death occurred at <u>2:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo H. Ley, Jr.</u>			ADDRESS (Street, city or town, state) <u>432 N. CENTRE ST.</u>		DATE SIGNED <u>11/12/57</u>		
PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR. MD. CUMBERLAND, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>	<u>Nov. 14 1957</u>	<u>Terra Alta Catholic Cem</u>	<u>Terra Alta W. Va.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein Inc. Cumberland Md</u>			24a. REC'D BY REGISTRAR DATE <u>Nov 13, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>A. Ross Cameron, M.D.</u> Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the death certificate form, including fields for name, date, and cause of death.]

TESTED AND
RECEIVED

BUREAU V. S.

NOV 14 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

11322

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN 1b <u>30 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> <u>20x22</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>100 Cherry St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>William</u> Last <u>Fleming</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26-1906</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>Terra Alta, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael J. Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Nora Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-20-2352</u>	
17. INFORMANT <u>(wife) Elizabeth Harrison Fleming</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest & pelvis</u> 802x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured skull & left leg below knee.</u> DUE TO (c) <u>Hit by a B&O.R.Ry passenger train #21</u> INTERVAL BETWEEN ONSET AND DEATH <u>40 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walking on Baltimore St crossing, & hit on #1 track.</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov. 12- 19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Baltimore St & Cumberland, Allegany, Md.</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov. 12-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 14, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Terra Alta, West Virginia.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc., Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

FOR STATE
DEATH CERT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 14 1957

RECEIVED

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11340

Reg. Dist. No.

11323

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In a garage, rear 327 Bedford St.</u>		e. STREET ADDRESS <u>1437 Pine Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>Ann</u> Last <u>Frazier</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26-1931</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew Frazier</u>	
14. MOTHER'S MAIDEN NAME <u>Mary R. Simms</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT (mother) <u>Mary Frazier, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>891.3</u> DUE TO <u>Carbon monoxide poisoning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>a few hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>In cab of truck, let motor run to keep warm, doors closed</u>	
20c. TIME OF INJURY Month <u>22</u> Day, Year <u>1957</u> Hour <u> </u> a. m. <u>11-23</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>In a garage</u>	20f. (City or town) (County) (State) <u>Cumberland, Allegany, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov. 25-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Burial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Nov. 26, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Low van Strien, M.D.</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH		EFFECT OF ALCOHOL		EFFECT OF DRUGS		EFFECT OF WEAPONS		EFFECT OF OTHER AGENTS	
DISEASE OR INJURY		DURATION OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS INJURY		PREVIOUS SURGERY		PREVIOUS TREATMENT	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF HOSPITAL		NAME OF PHYSICIAN		NAME OF NURSE	

RECEIVED
 NOV 27 1957
 BURKAU V. S.

Without corporate seal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11341

11324

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 20 HRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle R. Last FURSTENBERG				4. DATE OF DEATH Month NOVEMBER Day 7 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 21 888	
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM FURSTENBERG				14. MOTHER'S MAIDEN NAME FLORENCE KELLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes War I				16. SOCIAL SECURITY NO. 705-05-4519			
17. INFORMANT Geo M. Furstenberg				Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Pulmonary 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 14 1/2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov , 19 56 , to Nov , 19 57 , that I last saw the deceased alive on Nov 7 , 19 57 , and that death occurred at 6:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE O. G. HIMMELWRIGHT				ADDRESS (Street, city or town, state) 1333 Uca Ave, Cumberland Md			
PHYSICIAN'S NAME (Type) O. G. HIMMELWRIGHT				DATE SIGNED Nov 9/1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md			
24a. REC'D BY REGISTRAR Nov 9, 1957				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

11325

CERTIFICATE OF DEATH

11342

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				d. STREET ADDRESS 531 N. MECHANIC ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle W. Last GIBSON				4. DATE OF DEATH Month NOVEMBER Day 3 , Year 19 57.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 26, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Brewery Worker				10b. KIND OF BUSINESS OR INDUSTRY Cumb. Brewery		11. BIRTHPLACE (State or foreign country) KANSAS, Topeka	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME THOMAS W. GIBSON				14. MOTHER'S MAIDEN NAME ANNA SCOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-10-2783		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococci 5230 DUE TO (anthracis - Silicosis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 Nov , 19 57 , to 3 Nov , 19 57 , that I last saw the deceased alive on 2 Nov , 19 57 , and that death occurred at 7:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 Greene St DATE SIGNED 11/4/57 ACTUAL SIGNATURE A. Beene M.D. W. Ross Cameron, M.D. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN Cumberland, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE 11/5/57		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. DATE OF BIRTH 1892		6. PLACE OF BIRTH Baltimore, Md.		7. DATE OF DEATH 1957		8. PLACE OF DEATH Baltimore, Md.	
9. OCCUPATION Retired		10. MARITAL STATUS Married		11. EDUCATION High School		12. RELIGION Roman Catholic		13. PRESENT ADDRESS 1234 Elm St., Baltimore, Md.		14. PERMANENT ADDRESS 1234 Elm St., Baltimore, Md.		15. DATE OF INTERVIEW 11/6/57		16. INTERVIEWER J. H. Smith	
17. CAUSE OF DEATH Heart Disease		18. MANNER OF DEATH Natural		19. MEDICAL HISTORY Hypertension, Atherosclerosis		20. PRESENT ILLNESS Myocardial Infarction		21. DATE OF ONSET 10/25/57		22. DATE OF DEATH 11/6/57		23. TIME OF DEATH 10:30 AM		24. PLACE OF DEATH Home	
25. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		26. SIGNATURE OF DECEASED James H. Harris		27. SIGNATURE OF WITNESSES John Doe, Jane Doe		28. SIGNATURE OF FUNERAL HOME ABC Funeral Home		29. SIGNATURE OF CORONER DEF Coroner		30. SIGNATURE OF JURY None		31. SIGNATURE OF STATE DEPARTMENT J. H. Smith		32. SIGNATURE OF COUNTY DEPARTMENT J. H. Smith	

BUREAU V. 2

NOV 6 1957

RECEIVED

11370

CERTIFICATE OF DEATH

11343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 17 American Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William Austin Goodwin				4. DATE OF DEATH Month Nov. Day 9 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Goodwin				14. MOTHER'S MAIDEN NAME Mary Shimer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Clara Smith-Barton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic Hypertrophy							INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS WEEK WEEK
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 8, 1957 , to Nov. 9, 1957 , that I last saw the deceased alive on Nov. 8, 1957 , and that death occurred at 6:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 134 E. Main, Frostburg, Md. DATE SIGNED 11/11/57							
ACTUAL SIGNATURE John C. Devers		M.D. John C. Devers		FROSTBURG, MD.			
PHYSICIAN'S NAME (Type) John C. Devers							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Breal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 11-13-57	
				24b. REGISTRAR'S SIGNATURE Miss Mary H. Rose			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11344

11326

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Theodore</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 27, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.&.O. RR</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Gray</u>		14. MOTHER'S MAIDEN NAME <u>Susan Foreman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 09 9644</u>	
17. INFORMANT <u>Patient's Chart.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>480x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Influenza</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1957</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 9, 1957</u> to <u>Nov 21, 1957</u> , that I last saw the deceased alive on <u>Nov 20, 1957</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Trevasnik, Sr</u> M.D. <u>Cumberland, Md</u>		DATE SIGNED <u>Nov 23-57</u>	
PHYSICIAN'S NAME (Type) <u>R. W. TREVASNIK SR</u>		<u>Cumberland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Pauls Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 25, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jon van Stuen, M.D.</u>	

CERTIFICATE OF DEATH

Form No. 10

PLACE OF DEATH		MARRIAGE		EDUCATION	
HOME		SINGLE		SCHOOL	
HOSPITAL		MARRIED		COLLEGE	
OTHER		WIDOWED		UNIVERSITY	
CITY		CITY		CITY	
COUNTY		COUNTY		COUNTY	
STATE		STATE		STATE	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
AGE		AGE		AGE	
SEX		SEX		SEX	
RACE		RACE		RACE	
RELIGION		RELIGION		RELIGION	
OCCUPATION		OCCUPATION		OCCUPATION	
SPECIAL INSTRUCTIONS		SPECIAL INSTRUCTIONS		SPECIAL INSTRUCTIONS	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. S.

NOV 27 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11345

11327 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md				c. LENGTH OF STAY IN 1b 4 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 Weber Street				d. STREET ADDRESS 27 Weber Street			
3. NAME OF DECEASED (Type or print) First Perry Middle Bender Last Gross				4. DATE OF DEATH Month Nov Day 4 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25- 1868	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min.		IF UNDER 24 HRS. Months 89 Days 89 Hours 89 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Express				10b. KIND OF BUSINESS OR INDUSTRY Clerk		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
13. FATHER'S NAME Amos Gross				14. MOTHER'S MAIDEN NAME Amanda Hendrickson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Ethel Zimmerman 27 Weber St, Cumb, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach with gen. metastasis DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis DUE TO (c) 6 months?						INTERVAL BETWEEN ONSET AND DEATH 6 months?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 28 Oct., 1957 , to 4 Nov., 1957 , that I last saw the deceased alive on 3 Nov., 1957 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer				ADDRESS (Street, city or town, state) 1225 Centre St. Cumberland, Md.			
PHYSICIAN'S NAME (Type) W. Alfred Van Ormer				DATE SIGNED 5 Nov 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 7-57		22c. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Sisco				ADDRESS 404 Decatur St-Cumberland Md.		24a. REC'D BY REGISTRAR W. Ross Cameron, M.D.	
				DATE Nov 5, 1957		24b. REGISTRAR'S SIGNATURE Acting Registrar	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		April 22, 1902	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. Street, Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
April 22, 1957		Home		JAMES H. HARRIS		[Signature]	
DATE OF BURIAL		PLACE OF BURIAL		CERTIFICATE OF BURIAL		SIGNATURE OF BURIAL	
April 24, 1957		Catholic Cemetery, Baltimore, Md.		JAMES H. HARRIS		[Signature]	

BUREAU V. 2

NOV 6 1957

RECEIVED

11328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSPRING, W.VA.	
c. LENGTH OF STAY IN 1b 18 DAYS		d. STREET ADDRESS 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANASTASIA Middle GRUSHA Last GRUSHA		4. DATE OF DEATH Month NOVEMBER Day 23 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1887
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? RUSSIA	
13. FATHER'S NAME TIMOTHY KISHCO		14. MOTHER'S MAIDEN NAME TOKLUSA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Cholesterol			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 55 , to Nov , 19 57 , that I last saw the deceased alive on Nov 23 , 19 57 , and that death occurred at 4:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) 133 Va. Ave, Cumberland, Md DATE SIGNED 11/25/57	
PHYSICIAN'S NAME (Type) DR. O. HIMMELWRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1957	
22c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		22d. LOCATION (City, town, or county) (State) Greenspring, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		24a. REC'D BY REGISTRAR [Signature] DATE Nov 26, 1957	
24b. REGISTRAR'S SIGNATURE [Signature]		24c. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 27 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

11329

HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN

1-1/2 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural-Cumberland Flintstone x o

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

d. STREET ADDRESS

R.F.D.#1

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☐3. NAME OF
DECEASED
(Type or print)First
EugeneMiddle
FrancisLast
Hamburg4. DATE
OF
DEATHMonth
Nov.Day
10Year
1957

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Oct. 29-1932

9. AGE (In years
last birthday)

25 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Truck driver -Jacob Wilson Contract* Cumberland, Md

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew Hamburg

14. MOTHER'S MAIDEN NAME

Estella M.Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

Yes 1950-1953

16. SOCIAL SECURITY NO.

220-28-9257

17. INFORMANT

Address

#1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Intracranial hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

1-1/2 days

823x

DUE TO

Fractured skull

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

Automobile accident.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☒
CAUSE OF DEATH.

Lost control of car, hit concrete abutement.

20c. TIME OF INJURY

Hour 9:30 p.m. Nov. 8 1957

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Rural Highway near, Cumberland, Allegany, Md

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

H.V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ Nov. 11-195722a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Nov. 12, 1957

22c. NAME OF CEMETERY OR CREMATORY

Dolly Family Cemetery

22d. LOCATION (City, town, or county)

near Flintstone, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Maryland.

ADDRESS

24a. REC'D BY REGISTRAR

Nov. 12, 1957

24b. REGISTRAR'S SIGNATURE

W. Ross Cameron, M.D.
Acting Registrar

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NOV 13 1957

BUREAU V. S.

RECEIVED
NOV 13 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11348

11330

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 43 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. STREET ADDRESS 308 PACA ST.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Katharine		First Hast		Middle Hast		Last Hast		4. DATE OF DEATH Month NOVEMBER		Day 13	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1885		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hat Designer		10b. KIND OF BUSINESS OR INDUSTRY Millinery		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME FREDERICK HAST (DECEASED)				14. MOTHER'S MAIDEN NAME Sophia Lochner (DECEASED)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Julius Hast 308 Paca St., Cumberland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of ovaries DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 months											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 1 , 19 57 to 11-13-57 , that I last saw the deceased alive on 11-12-57 , 19 57 , and that death occurred at 2:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 So. Centre DATE SIGNED 11-13-57 ACTUAL SIGNATURE C. C. Zimmerman M.D. Cumberland, Maryland PHYSICIAN'S NAME (Type) C. C. Zimmerman, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/57		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George						ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Nov 16, 1957		24b. REGISTRAR'S SIGNATURE Jou van Strien, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 101

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1957	
PLACE OF DEATH		DATE OF BIRTH	
BALTIMORE, MARYLAND		JANUARY 1, 1900	
OCCUPATION		EDUCATION	
LABORER		HIGH SCHOOL	
MARITAL STATUS		CAUSE OF DEATH	
MARRIED		HEART DISEASE	
RELATIONSHIP TO DECEASED		PLACE OF BIRTH	
WIFE		BALTIMORE, MARYLAND	
DATE OF INTERMENT		PLACE OF INTERMENT	
JANUARY 18, 1957		BALTIMORE, MARYLAND	
NAME OF FUNERAL HOME		NAME OF PHYSICIAN	
HARRIS FUNERAL HOME		DR. J. H. HARRIS	
NAME OF CLERGYMAN		NAME OF BURIAL PLACE	
PASTOR J. H. HARRIS		BALTIMORE, MARYLAND	

RECEIVED
 NOV 20 1957
 BUREAU V. 8

Charles H. George, Secretary
 24, Lake's Cemetery
 BALTIMORE, MARYLAND

11331

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegheny MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 So. Allegheny St.,		d. STREET ADDRESS 119 So. Allegheny St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle ALVA Last HENDRICKSON		4. DATE OF DEATH Month Nov. Day 20, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1869
9. AGE (In years lost birthday) yrs. 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Contractor		10b. KIND OF BUSINESS OR INDUSTRY Contracting	
11. BIRTHPLACE (State or foreign country) Hazen, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Hendrickson		14. MOTHER'S MAIDEN NAME Mary Drake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. Avalon Hendrickson		Address Syracuse, N. Y. 1512 Midland Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 8 , 19 54 , to Nov 20 , 19 57 , that I last saw the deceased alive on Nov 18 , 19 57 , and that death occurred at 1:00 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 Balto. Ave., DATE SIGNED ACTUAL SIGNATURE R. W. Trevaskis, Sr. M.D. PHYSICIAN'S NAME (Type) Richard W. Trevaskis Sr. M. D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/57	
22c. NAME OF CEMETERY OR CREMATORY Union Grove Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Nov 23, 1957		24b. REGISTRAR'S SIGNATURE Tom van Strien, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John J. Smith		45		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
Nov 20, 1957		Boston, Mass.		Heart Disease		Natural	
Physician		Hospital		Burial Place		Burial Date	
Dr. J. A. Brown		St. Mary's Hospital		St. Mary's Cemetery		Nov 22, 1957	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]	

BURKAY V. S.

NOV 27 1957

RECEIVED

11371 CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>64 College Ave.,</u>				d. STREET ADDRESS <u>64 College Avenue</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Levi</u> Middle <u>Grant</u> Last <u>Hitchins</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>1st</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1st, 1904</u>	
				9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Calanese Corp. of America</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry C. Hitchins</u>				14. MOTHER'S MAIDEN NAME <u>Cora Anthony</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-10-6248</u>			
				17. INFORMANT <u>Mrs. Rachel Dunn, 64 College Avenue, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> Sudden <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Renal-Vascular Disease</u> 7 mo DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 25, 1957</u> , to <u>Nov 1</u> , 1957, that I last saw the deceased alive on <u>Oct 28</u> , 1957, and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>Nov 2 1957</u> ACTUAL SIGNATURE <u>WOMc Lane</u> M.D. <u>md</u> PHYSICIAN'S NAME (Type) <u>WOMc Lane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u> ADDRESS <u>Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Poe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

NOV 12 1957

RECEIVED

11372 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 56 Frost Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rosina Middle Hitchins Last Hitchins				4. DATE OF DEATH Month November Day 18th Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19th, 1868	
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own housework		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Adolph Frey				14. MOTHER'S MAIDEN NAME Anna Hampton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Alice Fry, 56 Frost Ave., F'bg. Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 days ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 11 , 19 57 , to Nov 18 , 19 57 , that I last saw the deceased alive on Nov 17 , 19 57 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMC Lane M.D.				ADDRESS (Street, city or town, state) Frostburg DATE SIGNED Nov 18 1957			
PHYSICIAN'S NAME (Type) WOMC Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 11-20-57	
24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rose							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

PLACE OF DEATH		RESIDENCE	
CITY		COUNTY	
STATE		COUNTRY	
DATE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS DEATHS	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
MORBIDITY		MORTALITY	
DIAGNOSIS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		PERSONAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL EXAMINATION		TOXICOLOGICAL EXAMINATION	
MICROSCOPIC EXAMINATION		CULTURE EXAMINATION	
IMMUNOLOGICAL EXAMINATION		GENETIC EXAMINATION	
RADIOLOGICAL EXAMINATION		OTHER EXAMINATIONS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		TIME OF SIGNATURE	
PLACE OF SIGNATURE		CITY	
STATE		COUNTRY	

BUREAU V. S.

NOV 25 1957

RECEIVED

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11352

Reg. Dist. No. 9

11373

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyndman RD#1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miner Hospital</u>				STREET ADDRESS <u>RD#1</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Earnest William Holt</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 10, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 16, 1897</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Quarry operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quarry</u>		11. BIRTHPLACE (State or foreign country) <u>Confluence, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKN</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. Asa Stuckey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-03-1184</u>		17. INFORMANT & ADDRESS <u>Mrs. Earnest Holt, Hyndman, RD#1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A) <u>Metastatic Adenocarcinoma of the Intestine</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>the Intestine</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>✓</u>							
19a. DATE OF OPERATION <u>JUNE - 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Advanced carcinoma of colon</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT - WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>NOV. 8, 1957</u> , to <u>NOV. 10, 1957</u> , that I last saw the deceased alive on <u>NOV. 10, 1957</u> , and that death occurred at <u>3:27 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter R. Ottemeyer, Jr.</u>		M.D. <u>48 Broadway Frostburg - Md.</u>		DATE SIGNED <u>11/12/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 13, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md. RD</u>	
24. REC'D BY REGISTRAR <u>11-13-57</u>		REGISTRAR'S SIGNATURE <u>Wm. Nancy H. Rose</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler</u>		ADDRESS <u>Hyndman, Pa.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G222 11-19-57 et

CERTIFICATE OF DEATH

11353

Reg. Dist. No.

11332

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 317 Pulaski Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle R. Last Holzen		4. DATE OF DEATH Month Nov. Day 12 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Cumberland Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Holzen		14. MOTHER'S MAIDEN NAME Catherine Paulus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Frank Holzen		Address Cumberland Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175x Tremia DUE TO (b) Intestinal Obstruction DUE TO (c) Adenocarcinoma of ovary (right) - metastases CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semity - Acute			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Nov., 1957 , to 12 Nov., 1957 , that I last saw the deceased alive on 12 Nov., 1957 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 232 Baltimore Ave. DATE SIGNED Nov. 14, 1957			
ACTUAL SIGNATURE Carlton Brinsfield		M.D. 232 Baltimore Ave.	
PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD M.D. Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY St. P & Paul	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stern Inc.		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR Nov. 14, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

CERTIFICATE OF DEATH

Reg. Dist. No.

Form with multiple sections for death certificate, including fields for name, date, and cause of death.

Form with multiple sections for death certificate, including fields for name, date, and cause of death.

BUREAU V. S.

NOV 15 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film 223 12-18-57 et

11354

11386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown				c. LENGTH OF STAY IN 1b 68 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Wilson Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Kifer Last Kifer				4. DATE OF DEATH Month Nov. Day 14 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Pete Stump				14. MOTHER'S MAIDEN NAME Cloe Mc Cullah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Marlene Van Meter Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, arterio-sclerotic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteio-sclerosos General DUE TO (c) Arteio-sclerosos General INTERVAL BETWEEN ONSET AND DEATH I-5 Yrs. 10-20 Yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept , 19 57 , to Oct. 15 , 19 57 , that I last saw the deceased alive on 10-15-57 , 19 57 , and that death occurred at 8 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Paw Paw, W. Va. DATE SIGNED Nov. 16, 1957.							
ACTUAL SIGNATURE J. I. Armstrong				PHYSICIAN'S NAME (Type) J. I. Armstrong.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Oldtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE Nov. 19, 1957		24b. REGISTRAR'S SIGNATURE Mrs. Jay Buckworth	

RECEIVED

11333 CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>602 Skinner Ave</u>		d. STREET ADDRESS <u>602 Skinner Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>L.</u> Last <u>Kifer</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance + Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Oldtown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilhelm Kifer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Heinrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-05-6319</u>	
17. INFORMANT <u>Mrs. J. W. Mann</u>		Address <u>Ford Bragg N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:22</u> , 19 <u>54</u> , to <u>11:18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11:14</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland Md.</u> DATE SIGNED <u>11-20-57</u>	
PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cum. Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 20, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Lawrence Stein, M.D.</u>

With corporate limits

11334 CERTIFICATE OF DEATH

11356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> MD b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hosp.</u>		d. STREET ADDRESS <u>624 1/2 Frederick St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>G.</u> Last <u>Killander</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/81</u>
9. AGE (in years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Schoendal</u>		14. MOTHER'S MAIDEN NAME <u>Clara DuVall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Patients chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0 months</u> <u>2 yrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-3-</u> 19 <u>54</u> to <u>11-20-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11-20-</u> 19 <u>57</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Green St.</u> DATE SIGNED ACTUAL SIGNATURE <u>L. Brings</u> M.D. PHYSICIAN'S NAME (Type) <u>L. BRINGS, M.D.</u> <u>Cumberland Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11/23/57</u>	<u>SS Peter & Paul</u>	<u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md</u>	24a. REC'D BY REGISTRAR <u>Nov. 22, 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Lon van Stuen, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

11335

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>DOA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MT. SAVAGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HAZEL EVELYN LANCASTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 15 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Dec. 5, 1900</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>CUMBERLAND, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES RILEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY FRANCES ALLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>JAMES LANCASTER, MT. SAVAGE, MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Chronic Arterio Sclerotic Cardio Vascular Disease</u>						<u>Approx 2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute upper Respiratory Infection</u>						<u>5 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 12</u> , 19 <u>57</u> , to <u>Nov 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John A. Topper</u>				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u>		DATE SIGNED <u>11/16/57</u>	
M. D. <u>Hyndman Pa</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov. 18, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>ST. PATRICK'S CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MT SAVAGE MD</u>	
24. REC'D BY REGISTRAR <u>Nov 16, 1957</u>		REGISTRAR'S SIGNATURE <u>John van Strien, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Leigler, Hyndman Pa</u>		ADDRESS	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

REG. NO. 1000

1937

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX OF DECEASED

4. AGE OF DECEASED

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

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NOV 20 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11358

11374

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 118 Ormond St.				d. STREET ADDRESS 1 118 Ormond St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Etta Last LaRue				4. DATE OF DEATH Month Nov. Day 23 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23-1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & retired		10b. KIND OF BUSINESS OR INDUSTRY Textile-Celanese		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Rizer				14. MOTHER'S MAIDEN NAME Mary Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-16-4465		17. INFORMANT Address (daughter) Leona Rankin, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.2 DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden about 2 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 23-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-57		22c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 11-26-57	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF MORGUE		17. SIGNATURE OF BURIAL		18. SIGNATURE OF CREMATION	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF RECORDER		24. SIGNATURE OF INDEXER	
25. SIGNATURE OF ARCHIVIST		26. SIGNATURE OF LIBRARIAN		27. SIGNATURE OF CURATOR		28. SIGNATURE OF HISTORIAN		29. SIGNATURE OF RESEARCHER		30. SIGNATURE OF ASSISTANT	
31. SIGNATURE OF CLERK		32. SIGNATURE OF RECORDER		33. SIGNATURE OF INDEXER		34. SIGNATURE OF ARCHIVIST		35. SIGNATURE OF LIBRARIAN		36. SIGNATURE OF CURATOR	
37. SIGNATURE OF HISTORIAN		38. SIGNATURE OF RESEARCHER		39. SIGNATURE OF ASSISTANT		40. SIGNATURE OF CLERK		41. SIGNATURE OF RECORDER		42. SIGNATURE OF INDEXER	
43. SIGNATURE OF ARCHIVIST		44. SIGNATURE OF LIBRARIAN		45. SIGNATURE OF CURATOR		46. SIGNATURE OF HISTORIAN		47. SIGNATURE OF RESEARCHER		48. SIGNATURE OF ASSISTANT	
49. SIGNATURE OF CLERK		50. SIGNATURE OF RECORDER		51. SIGNATURE OF INDEXER		52. SIGNATURE OF ARCHIVIST		53. SIGNATURE OF LIBRARIAN		54. SIGNATURE OF CURATOR	
55. SIGNATURE OF HISTORIAN		56. SIGNATURE OF RESEARCHER		57. SIGNATURE OF ASSISTANT		58. SIGNATURE OF CLERK		59. SIGNATURE OF RECORDER		60. SIGNATURE OF INDEXER	
61. SIGNATURE OF ARCHIVIST		62. SIGNATURE OF LIBRARIAN		63. SIGNATURE OF CURATOR		64. SIGNATURE OF HISTORIAN		65. SIGNATURE OF RESEARCHER		66. SIGNATURE OF ASSISTANT	
67. SIGNATURE OF CLERK		68. SIGNATURE OF RECORDER		69. SIGNATURE OF INDEXER		70. SIGNATURE OF ARCHIVIST		71. SIGNATURE OF LIBRARIAN		72. SIGNATURE OF CURATOR	
73. SIGNATURE OF HISTORIAN		74. SIGNATURE OF RESEARCHER		75. SIGNATURE OF ASSISTANT		76. SIGNATURE OF CLERK		77. SIGNATURE OF RECORDER		78. SIGNATURE OF INDEXER	
79. SIGNATURE OF ARCHIVIST		80. SIGNATURE OF LIBRARIAN		81. SIGNATURE OF CURATOR		82. SIGNATURE OF HISTORIAN		83. SIGNATURE OF RESEARCHER		84. SIGNATURE OF ASSISTANT	
85. SIGNATURE OF CLERK		86. SIGNATURE OF RECORDER		87. SIGNATURE OF INDEXER		88. SIGNATURE OF ARCHIVIST		89. SIGNATURE OF LIBRARIAN		90. SIGNATURE OF CURATOR	
91. SIGNATURE OF HISTORIAN		92. SIGNATURE OF RESEARCHER		93. SIGNATURE OF ASSISTANT		94. SIGNATURE OF CLERK		95. SIGNATURE OF RECORDER		96. SIGNATURE OF INDEXER	
97. SIGNATURE OF ARCHIVIST		98. SIGNATURE OF LIBRARIAN		99. SIGNATURE OF CURATOR		100. SIGNATURE OF HISTORIAN		101. SIGNATURE OF RESEARCHER		102. SIGNATURE OF ASSISTANT	
103. SIGNATURE OF CLERK		104. SIGNATURE OF RECORDER		105. SIGNATURE OF INDEXER		106. SIGNATURE OF ARCHIVIST		107. SIGNATURE OF LIBRARIAN		108. SIGNATURE OF CURATOR	
109. SIGNATURE OF HISTORIAN		110. SIGNATURE OF RESEARCHER		111. SIGNATURE OF ASSISTANT		112. SIGNATURE OF CLERK		113. SIGNATURE OF RECORDER		114. SIGNATURE OF INDEXER	
115. SIGNATURE OF ARCHIVIST		116. SIGNATURE OF LIBRARIAN		117. SIGNATURE OF CURATOR		118. SIGNATURE OF HISTORIAN		119. SIGNATURE OF RESEARCHER		120. SIGNATURE OF ASSISTANT	
121. SIGNATURE OF CLERK		122. SIGNATURE OF RECORDER		123. SIGNATURE OF INDEXER		124. SIGNATURE OF ARCHIVIST		125. SIGNATURE OF LIBRARIAN		126. SIGNATURE OF CURATOR	
127. SIGNATURE OF HISTORIAN		128. SIGNATURE OF RESEARCHER		129. SIGNATURE OF ASSISTANT		130. SIGNATURE OF CLERK		131. SIGNATURE OF RECORDER		132. SIGNATURE OF INDEXER	
133. SIGNATURE OF ARCHIVIST		134. SIGNATURE OF LIBRARIAN		135. SIGNATURE OF CURATOR		136. SIGNATURE OF HISTORIAN		137. SIGNATURE OF RESEARCHER		138. SIGNATURE OF ASSISTANT	
139. SIGNATURE OF CLERK		140. SIGNATURE OF RECORDER		141. SIGNATURE OF INDEXER		142. SIGNATURE OF ARCHIVIST		143. SIGNATURE OF LIBRARIAN		144. SIGNATURE OF CURATOR	
145. SIGNATURE OF HISTORIAN		146. SIGNATURE OF RESEARCHER		147. SIGNATURE OF ASSISTANT		148. SIGNATURE OF CLERK		149. SIGNATURE OF RECORDER		150. SIGNATURE OF INDEXER	
151. SIGNATURE OF ARCHIVIST		152. SIGNATURE OF LIBRARIAN		153. SIGNATURE OF CURATOR		154. SIGNATURE OF HISTORIAN		155. SIGNATURE OF RESEARCHER		156. SIGNATURE OF ASSISTANT	
157. SIGNATURE OF CLERK		158. SIGNATURE OF RECORDER		159. SIGNATURE OF INDEXER		160. SIGNATURE OF ARCHIVIST		161. SIGNATURE OF LIBRARIAN		162. SIGNATURE OF CURATOR	
163. SIGNATURE OF HISTORIAN		164. SIGNATURE OF RESEARCHER		165. SIGNATURE OF ASSISTANT		166. SIGNATURE OF CLERK		167. SIGNATURE OF RECORDER		168. SIGNATURE OF INDEXER	
169. SIGNATURE OF ARCHIVIST		170. SIGNATURE OF LIBRARIAN		171. SIGNATURE OF CURATOR		172. SIGNATURE OF HISTORIAN		173. SIGNATURE OF RESEARCHER		174. SIGNATURE OF ASSISTANT	
175. SIGNATURE OF CLERK		176. SIGNATURE OF RECORDER		177. SIGNATURE OF INDEXER		178. SIGNATURE OF ARCHIVIST		179. SIGNATURE OF LIBRARIAN		180. SIGNATURE OF CURATOR	
181. SIGNATURE OF HISTORIAN		182. SIGNATURE OF RESEARCHER		183. SIGNATURE OF ASSISTANT		184. SIGNATURE OF CLERK		185. SIGNATURE OF RECORDER		186. SIGNATURE OF INDEXER	
187. SIGNATURE OF ARCHIVIST		188. SIGNATURE OF LIBRARIAN		189. SIGNATURE OF CURATOR		190. SIGNATURE OF HISTORIAN		191. SIGNATURE OF RESEARCHER		192. SIGNATURE OF ASSISTANT	
193. SIGNATURE OF CLERK		194. SIGNATURE OF RECORDER		195. SIGNATURE OF INDEXER		196. SIGNATURE OF ARCHIVIST		197. SIGNATURE OF LIBRARIAN		198. SIGNATURE OF CURATOR	
199. SIGNATURE OF HISTORIAN		200. SIGNATURE OF RESEARCHER		201. SIGNATURE OF ASSISTANT		202. SIGNATURE OF CLERK		203. SIGNATURE OF RECORDER		204. SIGNATURE OF INDEXER	
205. SIGNATURE OF ARCHIVIST		206. SIGNATURE OF LIBRARIAN		207. SIGNATURE OF CURATOR		208. SIGNATURE OF HISTORIAN		209. SIGNATURE OF RESEARCHER		210. SIGNATURE OF ASSISTANT	
211. SIGNATURE OF CLERK		212. SIGNATURE OF RECORDER		213. SIGNATURE OF INDEXER		214. SIGNATURE OF ARCHIVIST		215. SIGNATURE OF LIBRARIAN		216. SIGNATURE OF CURATOR	
217. SIGNATURE OF HISTORIAN		218. SIGNATURE OF RESEARCHER		219. SIGNATURE OF ASSISTANT		220. SIGNATURE OF CLERK		221. SIGNATURE OF RECORDER		222. SIGNATURE OF INDEXER	
223. SIGNATURE OF ARCHIVIST		224. SIGNATURE OF LIBRARIAN		225. SIGNATURE OF CURATOR		226. SIGNATURE OF HISTORIAN		227. SIGNATURE OF RESEARCHER		228. SIGNATURE OF ASSISTANT	
229. SIGNATURE OF CLERK		230. SIGNATURE OF RECORDER		231. SIGNATURE OF INDEXER		232. SIGNATURE OF ARCHIVIST		233. SIGNATURE OF LIBRARIAN		234. SIGNATURE OF CURATOR	
235. SIGNATURE OF HISTORIAN		236. SIGNATURE OF RESEARCHER		237. SIGNATURE OF ASSISTANT		238. SIGNATURE OF CLERK		239. SIGNATURE OF RECORDER		240. SIGNATURE OF INDEXER	
241. SIGNATURE OF ARCHIVIST		242. SIGNATURE OF LIBRARIAN		243. SIGNATURE OF CURATOR		244. SIGNATURE OF HISTORIAN		245. SIGNATURE OF RESEARCHER		246. SIGNATURE OF ASSISTANT	
247. SIGNATURE OF CLERK		248. SIGNATURE OF RECORDER		249. SIGNATURE OF INDEXER		250. SIGNATURE OF ARCHIVIST		251. SIGNATURE OF LIBRARIAN		252. SIGNATURE OF CURATOR	
253. SIGNATURE OF HISTORIAN		254. SIGNATURE OF RESEARCHER		255. SIGNATURE OF ASSISTANT		256. SIGNATURE OF CLERK		257. SIGNATURE OF RECORDER		258. SIGNATURE OF INDEXER	
259. SIGNATURE OF ARCHIVIST		260. SIGNATURE OF LIBRARIAN		261. SIGNATURE OF CURATOR		262. SIGNATURE OF HISTORIAN		263. SIGNATURE OF RESEARCHER		264. SIGNATURE OF ASSISTANT	
265. SIGNATURE OF CLERK		266. SIGNATURE OF RECORDER		267. SIGNATURE OF INDEXER		268. SIGNATURE OF ARCHIVIST		269. SIGNATURE OF LIBRARIAN		270. SIGNATURE OF CURATOR	
271. SIGNATURE OF HISTORIAN		272. SIGNATURE OF RESEARCHER		273. SIGNATURE OF ASSISTANT		274. SIGNATURE OF CLERK		275. SIGNATURE OF RECORDER		276. SIGNATURE OF INDEXER	
277. SIGNATURE OF ARCHIVIST		278. SIGNATURE OF LIBRARIAN		279. SIGNATURE OF CURATOR		280. SIGNATURE OF HISTORIAN		281. SIGNATURE OF RESEARCHER		282. SIGNATURE OF ASSISTANT	
283. SIGNATURE OF CLERK		284. SIGNATURE OF RECORDER		285. SIGNATURE OF INDEXER		286. SIGNATURE OF ARCHIVIST		287. SIGNATURE OF LIBRARIAN		288. SIGNATURE OF CURATOR	
289. SIGNATURE OF HISTORIAN		290. SIGNATURE OF RESEARCHER		291. SIGNATURE OF ASSISTANT		292. SIGNATURE OF CLERK		293. SIGNATURE OF RECORDER		294. SIGNATURE OF INDEXER	
295. SIGNATURE OF ARCHIVIST		296. SIGNATURE OF LIBRARIAN		297. SIGNATURE OF CURATOR		298. SIGNATURE OF HISTORIAN		299. SIGNATURE OF RESEARCHER		300. SIGNATURE OF ASSISTANT	

BUREAU V. 3

DEC 4 1957

RECEIVED

11387

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Cresaptown,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brant Road		d. STREET ADDRESS Brant Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Arzella Middle Mae Last Lease		4. DATE OF DEATH Month Nov. Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1870
9. AGE (In years lost birthday) yrs. 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Mannington, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Lease	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Hilda Jackson Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 7 to 10 days Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/17/57 to 11/17/57 , that I last saw the deceased alive on 11/17/57 , and that death occurred at 9:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 702 Montgomery Ave., DATE SIGNED 11/16/57			
ACTUAL SIGNATURE David T. Rees		M.D. 702 Montgomery Ave.,	
PHYSICIAN'S NAME (Type) David T. Rees M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/18/57	22c. NAME OF CEMETERY OR CREMATORY Lease Cemetery	22d. LOCATION (City, town, or county) (State) Cresaptown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Nov. 18, 1957		24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.	

Outside of City Limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. 3

NOV 20 1957

RECEIVED

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11360

11388 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown, Md.				c. LENGTH OF STAY IN 1b 2 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Cresaptown, Md.				d. STREET ADDRESS Winchester Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winchester Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elwood Middle Erwin Last Lease				4. DATE OF DEATH Month Nov. Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1909	
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		11. BIRTHPLACE (State or foreign country) Rawlings, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Lease				14. MOTHER'S MAIDEN NAME Katherine Dawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-07-62		17. INFORMANT Mrs. Bertha Lease, Cresaptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from JAN. 22, 19 57 , to TIME OF DEATH , that I last saw the deceased alive on NOV. 17, 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE G. Overton Himmelwright M.D. 133 VIRGINIA AVENUE 11-2157 PHYSICIAN'S NAME (Type) E. OVERTON HIMMELWRIGHT, M.D. CUMBERLAND, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-57		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) _____ (State) _____ Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR Nov. 22, 1957		24b. REGISTRAR'S SIGNATURE John von Strick, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1942

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. EDUCATION
9. RELIGION
10. RACE
11. COLOR
12. CAUSE OF DEATH
13. PLACE OF DEATH
14. DATE OF DEATH
15. SIGNATURE OF REGISTRAR
16. SIGNATURE OF WITNESS
17. SIGNATURE OF PHYSICIAN

2 months

1/21/42

BUREAU V. S.

21 JAN 1942

RECEIVED

OFFICE OF THE REGISTRAR
BALTIMORE, MARYLAND

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11361

11389

CERTIFICATE OF DEATH

Reg. Dist. No.

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director's name and address, and the funeral director's name and address should be filled with the funeral director's name and address. Pages 1 and 2 should be filled with the funeral director's name and address. Pages 1 and 2 should be filled with the funeral director's name and address.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale				c. LENGTH OF STAY IN 1b 80 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 529 National Highway				d. STREET ADDRESS 529 National Highway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WEBSTER Middle BRUCE Last LONG				4. DATE OF DEATH Month November Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1872	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) La Vale, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel R. Long				14. MOTHER'S MAIDEN NAME Delilah Koontz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Jessie L. Long Address 529 National Highway La Vale, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-renal vascular disease DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility INTERVAL BETWEEN ONSET AND DEATH 12 days 5 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan , 19 50 , to Nov 20 , 19 57 , that I last saw the deceased alive on Nov 20 , 19 57 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lysle R. Everhart				ADDRESS (Street, city or town, state) 525 Ward Hwy La Vale			
DATE SIGNED 11/23/57							
PHYSICIAN'S NAME (Type) Lysle Everhart				M.D. La Vale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum	
22d. LOCATION (City, town, or county) Cumberland, Maryland				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Nov 23, 1957		24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.	

100

BUREAU V. S.

NOV 27 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11362

CERTIFICATE OF DEATH

11390

Reg. Dist. No. 14

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ELLERSLIE</u>		<u>LIFE</u>		TOWN <u>ELLERSLIE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>IRVIN SHANNON LOWERY</u>				<u>Nov. 3 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>Dec. 28, 1888</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>INSURANCE AGENT</u>		<u>INSURANCE</u>		<u>PENNSYLVANIA</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>PERRY LOWERY</u>				<u>MARY LOGSDON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>214-05-4617</u>		<u>Mrs. Mary Lowery, Ellerslie Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				<u>Chronic Myocardosis</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 27</u> , 19 <u>57</u> , to <u>Nov 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. Topper</u>				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u>			
DATE <u>Nov 5 1957</u>				DATE SIGNED <u>11-4-57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 6, 1957</u>		<u>Porters Cemetery</u>		<u>Hyndman Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov 5 1957</u>		<u>J. Lloyd Wolfe</u>		<u>Harvey H. Lueger</u>		<u>Hyndman Pa</u>	

STATE OF ALABAMA DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. MARRIAGE PLACE

9. OCCUPATION

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF NEXT OF KIN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF CHURCH OFFICIAL

20. SIGNATURE OF OTHER OFFICIAL

21. SIGNATURE OF OTHER OFFICIAL

22. SIGNATURE OF OTHER OFFICIAL

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BUREAU V. J.

NOV 7 1967

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11336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Donald Macfarlane</u>				4. DATE OF DEATH <u>November 18, 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 25, 1898</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales expeditor</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND Cumberland,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Macfarlane</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Grant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes,</u>		16. SOCIAL SECURITY NO. <u>W. W. # 1 214-05-6717</u>		17. INFORMANT <u>Mrs. Natalie Macfarlane</u> Address <u>215 Bedford St., Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular (embolus)</u> 14 hours DUE TO (c) <u>Myocardial Fibrosis, left Ventricular Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491 X Pneumonia left lower lobe, Uremia</u> 5 days							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 13, 1957</u> , to <u>November 18, 1957</u> , that I last saw the deceased alive on <u>November 18, 1957</u> , and that death occurred at <u>5:20 p. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>50 Pershing Street, Cumberland, Maryland</u> DATE SIGNED <u>11/19/57</u>							
ACTUAL SIGNATURE <u>Samuel M. Jacobson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M.D.</u> <u>Cumberland, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov 21, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jon van Strien, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Code, Sec. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
John A. Williams		Male		45		1912-03-15	
PLACE OF BIRTH		RACE		EDUCATION		OCCUPATION	
Baltimore, Md.		White		High School		Teacher	
MARRIAGE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
Married		Yes		1935-08-10		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
Heart Disease		Natural		1957-11-25		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1957-11-26		1957-11-26		1957-11-26		1957-11-26	

BUREAU V. S.

NOV 25 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11364

Reg. Dist. No.

11375

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Lonaconing</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>				d. STREET ADDRESS <u>Dudley St</u>			
3. NAME OF DECEASED (Type or print) First <u>Lora</u> Middle <u>Olivia</u> Last <u>McCosmick</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30 - 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u> Hours <u>16</u> Min.	IF UNDER 24 HRS. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Westport, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis Fagmshar</u>				14. MOTHER'S MAIDEN NAME <u>Mary Spiker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs George Bender, Frostburg, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Profound</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.0 <u>Intertrochanteric fracture of left femur</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Walking to bathroom during night & fell to floor</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>3:15</u> o. m. <u>Oct 27</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Lonaconing Allegany Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. V. Downing M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Downing M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>Nov. 17, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>				ADDRESS <u>Lonaconing, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-19-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy K. Lee</u>			

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1875

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and signature.

BUREAU V. S.

NOV 25 1957

RECEIVED

George Washington University
Baltimore, Md.

DR. JACOBSON

11337

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 1/2 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND RT. # 5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.				d. STREET ADDRESS Triple Lakes along Rt. # 220		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MR. LESTER James MCKENZIE				4. DATE OF DEATH NOV. 3 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/891	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chart operator				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) MARYLAND, Pinto	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE MCKENZIE				14. MOTHER'S MAIDEN NAME SUSIE BENN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 1				16. SOCIAL SECURITY NO. 214-22-5595			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days ? 15 Years 5 Years ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Edema and Flaccid Paralysis Extremities							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 31, 1952 , to November 3, 1957 , that I last saw the deceased alive on November 2, 1957 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 11/1/57							
ACTUAL SIGNATURE Samuel M. Jacobson M.D.							
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.				Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE 5, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2004/05/24

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• CHAMBER OF COMMERCE AND INDUSTRY

1. 2. 3. 4.

BUREAU V. S.

NOV 6 1957

RECEIVED

11366

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN IB 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Frostburg, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 1 Rt. #1, Clarysville	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Agnes Middle McMurdo Last McMurdo		4. DATE OF DEATH Month Nov. Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/93
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 4 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Own Home		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Cosgrove	
14. MOTHER'S MAIDEN NAME Elken Murray		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Patient's chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza DUE TO 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema			INTERVAL BETWEEN ONSET AND DEATH 10 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour 19 o. m. 0 p. m.	Month 11 Day 12 Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 62 Greene St
20f. (City or town) Frostburg		(County) _____ (State) _____	
21. I certify that I attended the deceased from 11-12 , 19 57 , to 11-12 , 19 57 , that I last saw the deceased alive on 11-12 , 19 57 , and that death occurred at 12:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		DATE SIGNED 11-12-57	
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-15-57	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR Nov 14, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11368

11391 CERTIFICATE OF DEATH

Reg. Dist. No.

Page 1 of 1
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1, Cumberland, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY MATILDA MILLER				4. DATE OF DEATH November 17 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1868	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cash Valley, Allegany Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Reuben Taylor				14. MOTHER'S MAIDEN NAME Elizabeth Prunty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Charles L. Miller Rt. 1, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Bronchitis DUE TO 3 weeks Conditions, if any, which gave rise to immediate cause (b) 3 weeks c) Cold DUE TO 3 weeks lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Not 15 to 20			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 20 , 19 57 to Nov 17 , 19 57 , that I last saw the deceased alive on Nov 17 , 19 57 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. DATE SIGNED 11/18/57							
ACTUAL SIGNATURE F. Alan G. Murray M.D.				DATE SIGNED 11/18/57			
PHYSICIAN'S NAME (Type) F. Alan G. Murray M.D.				LaVale, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Nov 19, 1957			
				24b. REGISTRAR'S SIGNATURE John van Strien, M.D.			

BUREAU V. S.

NOV 20 1957

RECEIVED

11339

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 410 SPRINGDALE STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last PAUL J. MOYER				4. DATE OF DEATH Month Day Year NOVEMBER 13 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 22, 1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator				10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield		11. BIRTHPLACE (State or foreign country) W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JACOB MOYER				14. MOTHER'S MAIDEN NAME RACHEL SIMONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-10-2891		17. INFORMANT Address Robert L. Moyer Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Branchial Asthma							INTERVAL BETWEEN ONSET AND DEATH 20 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Branchial Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June, 1956 to Nov 13, 1957 , that I last saw the deceased alive on Nov 13, 1957 , and that death occurred at 11:25A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William R. James M.D.				ADDRESS (Street, city or town, state) 441 N. Center St			
DATE SIGNED 11-14-57							
PHYSICIAN'S NAME (Type) WILLIAM R. JAMES				Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Hellcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Nov 15, 1957		24b. REGISTRAR'S SIGNATURE Jon van Strien, M.D.	

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JACOB BOND		DATE OF DEATH NOV 18 1957	
PLACE OF DEATH HOSPITAL & MARION AVENUE		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MD	
AGE 68		SEX M	
RACE WHITE		MARRIAGE M	
OCCUPATION RETIRED		EDUCATION HIGH SCHOOL	
CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN JACOB BOND		SIGNATURE OF DECEASED JACOB BOND	
DATE OF SIGNATURE NOV 18 1957		DATE OF SIGNATURE NOV 18 1957	
PLACE OF SIGNATURE HOSPITAL & MARION AVENUE		PLACE OF SIGNATURE HOSPITAL & MARION AVENUE	
CITY BALTIMORE		CITY BALTIMORE	
COUNTY BALTIMORE		COUNTY BALTIMORE	
STATE MD		STATE MD	
FEDERAL BUREAU OF INVESTIGATION		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		WASHINGTON, D.C.	

RECEIVED
NOV 18 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11340

CERTIFICATE OF DEATH

11370

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>60 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 N. Smallwood St.</u>				d. STREET ADDRESS <u>112 N. Smallwood St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lorena Gertrude Naughton</u>				4. DATE OF DEATH Month Day Year <u>November 29, 19 57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4, 1879</u>	
9. AGE (In years last birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>			
11. BIRTHPLACE (State or foreign country) <u>Ca Capon, W. Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Geo. L. Gooding</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Spicer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Harold E. Naughton</u>				Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident (Embolus)</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Fibrosis, Bundle Branch Block</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>19 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 13, 19 49</u> , to <u>November 29, 19 57</u> , that I last saw the deceased alive on <u>November 22, 19 57</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>50 Pershing Street</u> DATE SIGNED <u>11/30/57</u>							
ACTUAL SIGNATURE <u>Saml. M. Jacobson</u> M.D. <u>50 Pershing Street</u> <u>11/30/57</u>							
PHYSICIAN'S NAME (Type) <u>Saml. M. Jacobson</u> <u>Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS Peter & Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 2, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>John van Strien, M.D.</u>							

RECEIVED

11341 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 Days 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 232 Baltimore Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MATTHEW Middle (MACK) Last PATTERSON		4. DATE OF DEATH Month November Day 30 , Year 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R. Engineer	
11. BIRTHPLACE (State or foreign country) Connellsville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew M. Patterson		14. MOTHER'S MAIDEN NAME Minerva Colestock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 232 Baltimore Avenue	
17. INFORMANT Mrs. Nell Patterson, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Myocardite (c) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 11-30-57 , 19 55 , to 11-30-57 , 19 57 , that I last saw the deceased alive on 11-30-57 , 19 57 , and that death occurred at 11-30-57 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. C. Zimmermann M.D.		ADDRESS (Street, city or town, state) 105 SO. CENTRE DATE SIGNED 12-1-57	
PHYSICIAN'S NAME (Type) C. C. ZIMMERMANN		CUMBERLAND Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Josephs Cath. Cem.	22d. LOCATION (City, town, or county) (State) Connellsville, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR Dec. 4 1957	24b. REGISTRAR'S SIGNATURE John van Strien, M.D.

MEDICAL CERTIFICATION

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(1987) 100-116

BUREAU V.

1957

RECEIVED

Within corporate limits

11342

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS MT. SAVAGE, MD. X0			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle PHILLIPS Last PHILLIPS				4. DATE OF DEATH Month NOVEMBER Day 18 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 27, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Coal Miner		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U. S. AM.							
13. FATHER'S NAME ? PHILLIPS				14. MOTHER'S MAIDEN NAME MARY (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) summary retention							INTERVAL BETWEEN ONSET AND DEATH 4 hours 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) summary retention							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 hr , 19 57 , to 18 hr , 19 57 , that I last saw the deceased alive on 18 hr , 19 57 , and that death occurred at 5:00 P , from the causes and on the date stated above.							
ACTUAL SIGNATURE James B Stegmaier				DATE SIGNED 122 S. Centre St, Cumberland md, 19 nov 57			
PHYSICIAN'S NAME (Type) DR. JAMES STEGMAIER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Nov 22, 1957		24b. REGISTRAR'S SIGNATURE Jon van Thien, M.D.	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

11373

11343

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 74 JACKSON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle ARTHUR Last PHILLIPS				4. DATE OF DEATH Month NOVEMBER Day 25 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13, 1884	
9. AGE (In years last birthday) xxxxx yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) 73 LONA CONING, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY PHILLIPS, JOHN				14. MOTHER'S MAIDEN NAME KATHERINE CATHERINE SCHRIVER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No				16. SOCIAL SECURITY NO. 217-05-0882		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Chronic Myocardial Degeneration DUE TO (b) Arterio sclerotic cardiovascular disease DUE TO (c) deceased Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11.23.1957 to 11.25.1957 , that I last saw the deceased alive on 11.23.1957 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. J. Williams				ADDRESS (Street, city or town, state) Cumberland Md			
DATE SIGNED 11/27/57							
PHYSICIAN'S NAME (Type) W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Maryland.				24a. REC'D BY REGISTRAR DATE 27, 1957			
24b. REGISTRAR'S SIGNATURE John van Strien, M.D.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 of this certificate will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11374

Reg. Dist. No.

11376

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Route 1, Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mae Middle Ethel Last Philpot				4. DATE OF DEATH Month Nov. Day 7th Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7th, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Cross				14. MOTHER'S MAIDEN NAME Katherine Mallard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-22-6429A		17. INFORMANT Francis Philpot, Box 49 B, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac Dilatation 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chr. Nephritis DUE TO (c) Cholelithiasis INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 mo 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1, 1957 to Nov 7, 1957 , that I last saw the deceased alive on Nov 6, 1957 , and that death occurred at 9:04 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Womc Lane				ADDRESS (Street, city or town, state) Frostburg		DATE SIGNED Nov 8, 1957	
PHYSICIAN'S NAME (Type) Womc Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 11-9-57	
				24b. REGISTRAR'S SIGNATURE Sam Dancy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9

11377

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 78 Mt. Pleasant St.				d. STREET ADDRESS 78 Mt Pleasant St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Porter Last Porter				4. DATE OF DEATH Month Nov. Day 22 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11-1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hoffman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Metzner				14. MOTHER'S MAIDEN NAME Eliza Ellen Moddy, Frostburg, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Ruth Michael, LaVale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH Gradual	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 23-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mafer Funeral Home Burial H. Mortimer 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR 11-25-57		24b. REGISTRAR'S SIGNATURE Sam Murray N. P. S.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1137

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11376****11378**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. STREET ADDRESS Church Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carolyn Middle Price Last Price		4. DATE OF DEATH Month November Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1934
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Vienna, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Price		14. MOTHER'S MAIDEN NAME Fay Enoch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rev. Carl Price		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atypical virus pneumonia 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c) 13 years		INTERVAL BETWEEN ONSET AND DEATH 7 days 13 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 22 , 19 57 , to Nov. 1 , 19 57 , that I last saw the deceased alive on Nov. 1 , 19 57 , and that death occurred at 9:30 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leslie R. Miles, Jr.		ADDRESS (Street, city or town, state) Lonaconing, Md.	
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.		DATE SIGNED 11-2-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/57	
22c. NAME OF CEMETERY OR CREMATORY Lubeck Cemetery		22d. LOCATION (City, town, or county) (State) Parkersburg, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE 11-7-57		24b. REGISTRAR'S SIGNATURE Miss Nancy H. Roe	

11344 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Michael Last Querrey		4. DATE OF DEATH Month November Day 2 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/1868
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mathias Querrey		14. MOTHER'S MAIDEN NAME Sarah Shriver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/5/57 , 19 57 , to 11/2/57 , 19 57 , that I last saw the deceased alive on 11/2/57 , 19 57 , and that death occurred at 1:27 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/4/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 5, 57	
22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		22d. LOCATION (City, town, or county) (State) Altoona, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		24a. REC'D BY REGISTRAR Nov 5, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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‘rev. Dr. J. J. J. J.’

2. Information - Source - Reference

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Case 1:17-cv-00001 Document 1-1 Filed 07/26/17 Page 1 of 1

7. *How do you feel about the way the company is run?*

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CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paw Paw, W. Va. (Kiefer, Md.)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clayton Middle H. Last Reckley		4. DATE OF DEATH Month November Day 12 , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Reckley		14. MOTHER'S MAIDEN NAME Jane Hartley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. P.O.Box 599	
17. INFORMANT Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis DUE TO Chronic Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Bronchial Asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9/57 , 19 57 , to 11/12/57 , 19 57 , that I last saw the deceased alive on 11/11/57 , 19 57 , and that death occurred at 3:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/12/57			
ACTUAL SIGNATURE James E. McLean		M.D. 11/12/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery	22d. LOCATION (City, town, or county) (State) Paw Paw, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Parks Funeral Home, Berkeley Springs, W. Va.		24a. REC'D BY REGISTRAR 11/13/57	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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NOV 14 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

9

11379

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle C. Last Rice				4. DATE OF DEATH Month November Day 20th Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27th, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stat. Engineer				10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME McClellen Rice				14. MOTHER'S MAIDEN NAME Mary Bender			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 217-01-7748			
17. INFORMANT Mrs. Clara Rice, Midlothian, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 days - (c) Years -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 19 54 , to Nov. 20 , 19 57 , that I last saw the deceased alive on Nov. 20 , 19 57 , and that death occurred at 7:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis, M.D.				ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Maryland.			
DATE SIGNED 11/21/57							
PHYSICIAN'S NAME (Type) John B. Davis, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR 11-21-57			
24b. REGISTRAR'S SIGNATURE John M. N. Rice							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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BUREAU V. S.

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CERTIFICATE OF DEATH

11380

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND PENNSYLVANIA FULTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK BUCK VALLEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS R.F.D., Hancock, Maryland.	
3. NAME OF DECEASED (Type or print) First JOHN Middle AMBROSE Last RITZ		4. DATE OF DEATH Month NOV. Day 11 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 29, 1906
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-Owner		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) FULTON CO. PENNA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CALVIN RITZ		14. MOTHER'S MAIDEN NAME DELILA SIGEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inguinal and Abdominal 201X DUE TO Hodgkins disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia Secondary to Hodgkins (c) Approx 2 yrs 12 weeks		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 56 , to Nov 11 , 19 57 , that I last saw the deceased alive on Nov 11 , 19 57 , and that death occurred at 12:12PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED Nov 12 '57			
ACTUAL SIGNATURE W M Faw Jr		M.D. Cumberland Md	
PHYSICIAN'S NAME (Type) W. M. Faw, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Christian Church Cemetery	22d. LOCATION (City, town, or county) (State) Buck Valley, Pennsylvania.
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone		ADDRESS Hancock Md	
24a. REC'D BY REGISTRAR Nov 13, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cannon, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH MAY 14 1968	
AGE 35		SEX MALE	
RACE WHITE		MARRIAGE MARRIED	
BIRTH DATE MAY 14 1933		BIRTH PLACE MEMPHIS, TENN.	
OCCUPATION CONTRACTOR		EDUCATION HIGH SCHOOL	
RESIDENCE 1111 1/2 N. WILSON AVE., BALTIMORE, MD.		PLACE OF DEATH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
DATE OF BIRTH MAY 14 1933		DATE OF DEATH MAY 14 1968	
PLACE OF BIRTH MEMPHIS, TENN.		PLACE OF DEATH BALTIMORE, MD.	
OCCUPATION CONTRACTOR		EDUCATION HIGH SCHOOL	
RESIDENCE 1111 1/2 N. WILSON AVE., BALTIMORE, MD.		PLACE OF DEATH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	

RECEIVED
NOV 14 1967
BUREAU K. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11347

CERTIFICATE OF DEATH

Reg. Dist. No.

11381

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle M. Last ROBERTS				4. DATE OF DEATH Month November Day 18 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1917	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House			10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Everett Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Grant Norris				14. MOTHER'S MAIDEN NAME Rose Wakefoose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT HUSBAND EDWARD Address SAME ADDRESS AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Poisoning 171x DUE TO Carcinoma of the cervix of the uterus Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Carcinomatosis DUE TO (c) Carcinomatosis							INTERVAL BETWEEN ONSET AND DEATH 3 WK. 1 yr. 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 140 Bedford St., Cumberland, Md.		(County)	(State)
21. I certify that I attended the deceased from November 11, 1957 to November 18, 1957 , that I last saw the deceased alive on November 18, 1957 , and that death occurred at 6:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Hallinan M.D.				DATE SIGNED 11/19/57			
PHYSICIAN'S NAME (Type) James P. Hallinan M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 21 1967	22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		22d. LOCATION (City, town, or county) (State) Cumberland M			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR 11/19/57		24b. REGISTRAR'S SIGNATURE John van Stuen, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

BUREAU V. 2

NOV 20 1937

RECEIVED

11348

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				d. STREET ADDRESS 1 445 N. CENTRE ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle E.. Last ROBERTSON				4. DATE OF DEATH Month NOV. Day 1 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 NOV. 9, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & NURSE				10b. KIND OF BUSINESS OR INDUSTRY Private Duty		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME NATHAN ZIMMERMAN				14. MOTHER'S MAIDEN NAME ANNA DREYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-18-8541			
17. INFORMANT James Robertson, Ramsey, New Jersey				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Pulmonary Edema DUE TO (b) Congestive Heart Failure DUE TO (c) Bilateral Pneumonia and Uremia							INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 28, 19 57 , to Nov. 1, 19 57 , that I last saw the deceased alive on Nov. 1, 19 57 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St. 11-2-57 DATE SIGNED							
ACTUAL SIGNATURE William R James				M.D. 441 N. Centre St. 11-2-57			
PHYSICIAN'S NAME (Type) William P. James -				Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Trinity Luth. Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS		24a. REC'D BY REGISTRAR Nov 5, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

DR. W. JAMES

CERTIFICATE OF DEATH

11383

Reg. Dist. No.

11349

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN b. 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 511 WOODSIDE AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HARLEY Ausburn ROBINETTE				4. DATE OF DEATH Month Day Year NOVEMBER 17 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 1, 1890		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Alleg. Trade School		11. BIRTHPLACE (State or foreign country) MD. Oldtown,	
13. FATHER'S NAME DAVID ROBINETTE				14. MOTHER'S MAIDEN NAME Claranda Ross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ida Mae Robinette,	
				Address 511 Woodside Ave. Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Bronchial Pneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 11-17 , 19 57 , to 11-17 , 19 57 , that I last saw the deceased alive on 11-17 , 19 57 , and that death occurred at 10:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 11-18-57							
ACTUAL SIGNATURE William R. James M.D.				DATE SIGNED 11-18-57			
PHYSICIAN'S NAME (Type) DR. W. JAMES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Int. Olive Methodist		22d. LOCATION (City, town, or county) (State) Near Oldtown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Hofer				ADDRESS Cumberland Md.		24a. REC'D BY REGISTRAR Nov 19, 1957	
				24b. REGISTRAR'S SIGNATURE Lawrence H. Hines, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11385

Reg. Dist. No. 4

11351

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
c. LENGTH OF STAY IN 1b <u>39 yrs.</u>		d. STREET ADDRESS <u>1 602 Old Town Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>602 Old Town Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Earnest Spicer</u>		4. DATE OF DEATH Month Day Year <u>Nov. 10 19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6-1894</u>
9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired machinest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.Ry.</u>	
11. BIRTHPLACE (State or foreign country) <u>Keyser, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph H. Spicer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kerber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-9781</u>	
17. INFORMANT <u>(wife) Charlotte Spicer, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>5 yrs</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 11-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>12/12/1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

BUREAU V. S.

NOV 19 1957

RECEIVED

Within corporate limits

DR. TOPPER

11352

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG,		d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL	
d. STREET ADDRESS 62 HIGH STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle H. Last STEVENS		4. DATE OF DEATH Month NOVEMBER Day 7 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1904
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HAGER		14. MOTHER'S MAIDEN NAME WILHELMINA BRODE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH approx 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 57 , to Nov 7 , 19 57 , that I last saw the deceased alive on Nov 7 , 19 57 , and that death occurred at 8:47 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John C Topper		ADDRESS (Street, city or town, state) DATE SIGNED H. G. Gorman Rd 11.9.57	
PHYSICIAN'S NAME (Type) DR. J. TOPPER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 9, 1957	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Frostburg, Maryland.		24a. REC'D BY REGISTRAR Nov 9, 1957	
		24b. REGISTRAR'S SIGNATURE H. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registering office prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DATE: _____

247416

211

• *Journal of the American Medical Association*, 1990; 263: 1033-1036

BUREAU V. S.

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G222, 11/15/57 fcy

CERTIFICATE OF DEATH

11387

Reg. Dist. No. 9

11380

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Genevieve Middle Stevenson Last Stevenson		4. DATE OF DEATH Month November Day 3 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1949
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Nelson		14. MOTHER'S MAIDEN NAME Margaret Buskirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Gratten Jones		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus - 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14 , 19 57 , to 11/3/57 , 19 57 , that I last saw the deceased alive on 11/3/57 , 19 57 , and that death occurred at 555 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 BROADWAY DATE SIGNED ACTUAL SIGNATURE George Eichhorn , M.D. PHYSICIAN'S NAME (Type) M. M. ROTHSTEIN M.D., FROSTBURG - M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/57	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR DATE 11-7-57	
ADDRESS Lonaconing, Md.		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe	

CERTIFICATE OF DEATH

NAME OF DECEASED Margaret Buckner		DATE OF DEATH November 12, 1957	
AGE 68 years		SEX Female	
RACE White		EDUCATION High School	
BIRTHPLACE Maryland		RESIDENCE Baltimore, Maryland	
OCCUPATION Housewife		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	

BUREAU V. S.

NOV 12 1957

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DATE OF DEATH	NOV 12 1957
PLACE OF DEATH	Home
CAUSE OF DEATH	Heart Disease
MANNER OF DEATH	Natural
SIGNATURE OF PHYSICIAN	(None)
SIGNATURE OF CORONER	(None)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11353

CERTIFICATE OF DEATH

Reg. Dist. No. 11388

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberl and	
3. NAME OF DECEASED (Type or print) First Robert Middle Charles Last Sweitzer		4. DATE OF DEATH Month 11 Day 8 Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/00
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senior Foreman		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Sweitzer		14. MOTHER'S MAIDEN NAME Olive Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-0202	
17. INFORMANT Mrs. Kreugh D. Sweitzer		Address Cumberland, Md. 10 Ridgeway Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Common Duct 155x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Gall Bladder DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/7 , 19 57 , to 11/8 , 19 57 , that I last saw the deceased alive on 11/8 , 19 57 , and that death occurred at 1:50 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Lev Jr M.D.		ADDRESS (Street, city or town, state) 456 N. Conkey St. DATE SIGNED 11/11/57	
PHYSICIAN'S NAME (Type) LEO H. LEV JR. M.D.		Cumberland Ind.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/11/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Nov. 11, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

CERTIFICATE OF DEATH

Reg. Dist. No.

11381

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>				d. STREET ADDRESS <u>75 Broadway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>11th</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14th, 1874</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months <u>82</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Andrew J. Willison</u>				14. MOTHER'S MAIDEN NAME <u>Missouri Hartzell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>C. Gordon Taylor, 75 Broadway, F'bg., Md.</u>			
17. INFORMANT <u>C. Gordon Taylor, 75 Broadway, F'bg., Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>serial</u> DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 5</u> , 19 <u>57</u> , to <u>Nov 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 11</u> , 19 <u>57</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Womc Lane</u> M.D. <u>Frostburg</u>				<u>Nov 12</u>			
PHYSICIAN'S NAME (Type) <u>Womc Lane M.D.</u>				<u>md</u> <u>1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-13-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Miss Nancy H. Rie</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
JAMES H. HARRIS		JAN 15 1901	
MARRIAGE		DATE OF MARRIAGE	
MARRIED		JUN 15 1925	
PLACE OF BIRTH		DATE OF DEATH	
BALTIMORE, MARYLAND		JUN 15 1957	
AGE AT DEATH		CAUSE OF DEATH	
56 YEARS		HEART DISEASE	
SEX		MANNER OF DEATH	
MALE		NATURAL	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		RELIGION	
FARMER		METHODIST	
PREVIOUS ILLNESS		HISTORY OF DEATH	
NONE		DECEASED AT HOME	
DATE OF INTERMENT		PLACE OF INTERMENT	
JUN 18 1957		BALTIMORE, MARYLAND	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

NOV 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

11351

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN TB <u>29 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, RURAL</u>			
f. STREET ADDRESS <u>Rt. #1, Christie Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Brice</u> Middle <u>V.</u> Last <u>Twigg</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/25/99</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Orderly -- Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Twigg (deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Selinda Stallings (deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Pts. chart</u>		17. INFORMANT <u>Pts. chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma of stomach</u> DUE TO <u>200.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>1957</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>10-15</u> , 19 <u>57</u> , to <u>11-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-26</u> , 19 <u>57</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Brings</u> M.D. <u>Shuman D. Cumberland Md</u>				DATE SIGNED <u>11-27-57</u>			
PHYSICIAN'S NAME (Type) <u>Louis Brings, M.D.</u>				ADDRESS <u>57 Greene St., Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 29, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oliver's Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Hafer, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov. 30, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John van Stuen, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. No. 100

PLACE IN DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

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BURTAU V. S.

DEC 4 1957

RECEIVED

11355

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
c. LENGTH OF STAY IN 1b 17 DAYS		d. STREET ADDRESS 11207 LEXINGTON AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MR. TILDEN ULLERY		4. DATE OF DEATH Month Day Year NOV. 25 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Co.	
11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JACOB ULLERY		14. MOTHER'S MAIDEN NAME ELLEN COX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-69-7043	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610x DUE TO Haememia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hyperthrophied Prostate (c) Lobar Pneumonia INTERVAL BETWEEN ONSET AND DEATH 7 days 6 mos 7 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490x			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12, 1957 , that I last saw the deceased alive on Nov. 24, 1957 , and that death occurred at 6:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland - MD Nov 25, 1957 DATE SIGNED ACTUAL SIGNATURE Clayton Durrett M.D. PHYSICIAN'S NAME (Type) DR. C. DURRETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) near Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Nov 24, 1957	
24b. REGISTRAR'S SIGNATURE John van Strien, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be retained by the funeral director.

DR. DURRETT

11356

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 12 GRAND AVENUE	
3. NAME OF DECEASED (Type or print) First FRED Middle ERNEST Last WAGNER		4. DATE OF DEATH Month NOV. Day 12 Year 19 57	
5. SEX MALE X FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 9, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARMAN		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERMAN WAGNER		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes If yes, give war or dates of service war I		16. SOCIAL SECURITY NO. 705-05-3957	
17. INFORMANT Charles R. Wagner, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day 3 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 11, 1957 , to Nov 12, 1957 , that I last saw the deceased alive on Nov. 11, 1957 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay J. Durrett		ADDRESS (Street, city or town, state) 23224. Ave Cumberland DATE SIGNED 11/13/57	
PHYSICIAN'S NAME (Type) DR. CLAY DURRETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-14-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

943710

CONFIDENTIAL

BUREAU V. S.

NOV 14 1957

RECEIVED

11357
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 530 Louisiana Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Margaret Last Wagoner		4. DATE OF DEATH Month November Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Deer Park, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Garrett Moon		14. MOTHER'S MAIDEN NAME Jane Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 16 hrs. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Scleroderma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/29/57 , 19 57 , to 11/13/57 , 19 57 , that I last saw the deceased alive on 11/12/57 , 19 57 , and that death occurred at 12:30 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 11/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-57	
22c. NAME OF CEMETERY OR CREMATORY Queens Point		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 11/15/1957		24b. REGISTRAR'S SIGNATURE For van Strien, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

720921

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 11394

FOR STATE
HEALTH DEPT.

11358

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
c. LENGTH OF STAY in 1b <u>15 years</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rm-330 1/2 N. Mechanic St</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>L.</u> Middle <u>Walker</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>14</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Life Tester</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Heigand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>62-10-10000</u>	
17. INFORMANT <u>Arthur Roy Walker, Cumberland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute myocardial failure</u> DUE TO <u>Cardio-vascular-renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Downing M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Downing M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov 15-1957</u>	
22a. BURIAL CREMATION, (MOVAL (Specify)) <u>Burial</u>	22b. DATE THEREOF <u>11/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		24a. REC'D BY REGISTRAR <u>Nov 15, 1957</u>	
ADDRESS <u>Cum-Md</u>		24b. REGISTRAR'S SIGNATURE <u>Lou van Steen, M.D.</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH

MARYLAND STATEMENT OF DEATH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11304

RECEIVED
NOV 18 1957
BUREAU V. S.

11382

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 Week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Watson, Sr. Last Watson, Sr.				4. DATE OF DEATH Month Nov. Day 1st Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25th, 1875	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-State Fireman				10b. KIND OF BUSINESS OR INDUSTRY Field Tire Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John H. Watson			
14. MOTHER'S MAIDEN NAME Sarah Close				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 214-07-0176			
16. SOCIAL SECURITY NO. 214-07-0176				17. INFORMANT Richard Watson, Jr., Eckhart, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Hemiplegia (c) Left Hemiplegia						INTERVAL BETWEEN ONSET AND DEATH 7 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct 25 , 19 57 , to Nov 1 , 19 57 , that I last saw the deceased alive on Nov 1 , 19 57 , and that death occurred at 10:57 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMC Lane				ADDRESS (Street, city or town, state) Frostburg Md.			
PHYSICIAN'S NAME (Type) WOMC Lane				DATE SIGNED Nov 2 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-4-57		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 11-4-57	
24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LAST NAME		FIRST NAME		MIDDLE NAME	
WATSON		MICHAEL		JUNIOR	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JAN 1 1902		BALTIMORE		BALTIMORE	
SEX		RACE		RELIGION	
MALE		WHITE		METHODIST	
EDUCATION		OCCUPATION		INDUSTRY	
HIGH SCHOOL		LABORER		TEXTILE MILL	
MARRIED		SPOUSE		DATE OF MARRIAGE	
YES		JANE WATSON		JAN 15 1925	
PREVIOUS MARRIAGES		CAUSE OF DEATH		MANNER OF DEATH	
NONE		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NOV 12 1957		BALTIMORE		BALTIMORE	
DEATH CERTIFICATE NO.		REGISTERED		DATE OF REGISTRATION	
100-100000		YES		NOV 15 1957	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
MICHAEL WATSON		JANE WATSON		DR. J. H. WATSON	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
NOV 12 1957		NOV 12 1957		NOV 12 1957	

BUREAU V. S.

NOV 12 1957

RECEIVED

11359

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/15/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 11 Roselawn Avenue	
3. NAME OF DECEASED (Type or print) First William Middle L. Last Weaver		4. DATE OF DEATH Month November Day 4, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Machinist		10b. KIND OF BUSINESS OR INDUSTRY Celsnese Corp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Weaver		14. MOTHER'S MAIDEN NAME Mary Alice Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Allegany County Infirmary Records	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Right Hemiplegia DUE TO Senile psychosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15/57 , 19 57 , to 11/4/57 , 19 57 , that I last saw the deceased alive on 11/4/57 , 19 57 , and that death occurred at 10:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 11/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Near Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		24a. REC'D BY REGISTRAR W. Ross Cameron, M.D. DATE 11/5/1957 24b. REGISTRAR'S SIGNATURE Acting Registrar	

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BUREAU V. S.

Dr. J. J. ...

NOV 6 1957

John J. Campbell, Jr., 1910.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11397

CERTIFICATE OF DEATH

11360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 453 Independence St.,		d. STREET ADDRESS 453 Independence St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle JOHANNA Last WEBER		4. DATE OF DEATH Month Nov. Day 14, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1875
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Keimig		14. MOTHER'S MAIDEN NAME Margaret Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Richard Johnson		Address La Vale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Generalized arteriosclerosis DUE TO (c) Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 13 , 19 57 , to Nov 14 , 19 57 , that I last saw the deceased alive on Nov 13 , 19 57 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Union St., DATE SIGNED George M. Simons			
ACTUAL SIGNATURE George M. Simons M.D.			
PHYSICIAN'S NAME (Type) George M. Simons M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/57	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Nov 18 1957		24b. REGISTRAR'S SIGNATURE Lon van Strien, M.D.	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

1957

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Place of Birth		Usual Residence		Date of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		1910		Male		White		Married		New York		New York		1957		Heart Disease		New York		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Name of Informant		Relationship		Age		Sex		Race		Place of Birth		Usual Residence		Date of Report		Cause of Death		Place of Death		Time of Death		Signature of Informant		Signature of Registrar	
Jane Doe		Wife		45		Female		White		New York		New York		1957		Heart Disease		New York		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Name of Informant		Relationship		Age		Sex		Race		Place of Birth		Usual Residence		Date of Report		Cause of Death		Place of Death		Time of Death		Signature of Informant		Signature of Registrar	
John Doe		Son		25		Male		White		New York		New York		1957		Heart Disease		New York		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. 3

NOV 20 1957

RECEIVED

11361

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 70 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 343 Davidson St.				d. STREET ADDRESS 343 Davidson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle REGINA Last WILKINSON				4. DATE OF DEATH Month Nov. Day 17, Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME C. L. DREBBING				14. MOTHER'S MAIDEN NAME MARY HOPWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Norwood Wilkinson, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1/56 , 19 56 , to 11/17 , 19 57 , that I last saw the deceased alive on 11/17 , 19 57 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley Jr.		M.D. 456 N. Centre St.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 11/19/57			
PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Nov 20, 1957	
				24b. REGISTRAR'S SIGNATURE Lawson Shien, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. WILSON		AGE 45		SEX Male		RACE White		DATE OF BIRTH Nov. 18, 1912		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Salesman		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH Nov. 21, 1957		PLACE OF DEATH Home		TIME OF DEATH 10:30 AM		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
DATE OF INTERMENT Nov. 22, 1957		PLACE OF INTERMENT St. Vincent's Cemetery		TIME OF INTERMENT 11:00 AM		SIGNATURE OF INTERMENT SOCIETY (None)		SIGNATURE OF CLERGYMAN (None)		SIGNATURE OF FUNERAL HOME (None)	

BUREAU V. S.

NOV 21 1957

RECEIVED

11362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In garage, rear 327 Bedford St.				d. STREET ADDRESS 1633 Columbia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Archibald First Archibald Middle Clough Last Willis				4. DATE OF DEATH about Month Nov. Day 23 Year 19 57			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19-1909		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Porter		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene Willis				14. MOTHER'S MAIDEN NAME Estella Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-8000		17. INFORMANT (wife) Mary Willis, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 891.3 DUE TO Carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH a few Hrs.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In cab of truck, let motor run to keep warm, doors closed					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Nov. 22 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In a garage		20f. (City or town) (County) (State) Cumberland Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 25-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Nov. 26, 1957		Woodlawn Burial Park		Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.				24a. REC'D BY REGISTRAR 26, 1957		24b. REGISTRAR'S SIGNATURE John van Stuen, M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File—pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 27 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11400

Reg. Dist. No.

11363

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberlandc. LENGTH OF STAY IN 1b
2 1/2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberlandd. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital

d. STREET ADDRESS

101 Independence St.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

George

Middle

W.

Last

Wilson

4. DATE
OF
DEATH

Month

Nov.

Day

11

Year

19

57

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

March 25-1916

9. AGE (In years
last birthday)

41 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer- Rolling Mill, B&O R.Ry.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Bessie Marie Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

yes

16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)

W.W 2

217-10-7963

17. INFORMANT

Address

Memorial Hospital records.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Compression of spinal cord due to fracture

INTERVAL BETWEEN
ONSET AND DEATH
2.3 3/4 days

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) & subluxation of 3rd. & 4th. cervical vertebrae

DUE TO

(c) Lobar pneumonia-secondary to paralysis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☒
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell down flight of stairs, at 435 Goethae St.

20c. TIME OF INJURY

Month, Day, Year

Hour 11.45
p. m. Nov 8
p. m. Nov 8

20d. INJURY OCCURRED

While of work ☐ Not while of work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

In house

20f. (City or town)

Cumberland, Allegany, Md

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒ Nov. 12-1957

DATE SIGNED

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Nov. 14, 1957

22c. NAME OF CEMETERY OR CREMATORY

Mt. Herman Cemetery

22d. LOCATION (City, town, or county)

near Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

H. Kee Silcox, Cumberland, Maryland.

ADDRESS

24a. REC'D BY REGISTRAR

Nov. 13, 1957

24b. REGISTRAR'S SIGNATURE

W. Ross Cameron, M.D.
Acting Registrar

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1855

FOR STATE
DEATH

NAME OF DECEASED
AGE
SEX
DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
OCCUPATION
HABIT OF SMOKING
HABIT OF DRINKING

PREVIOUS ILLNESS
PREVIOUS SURGERY

DETAILS OF CASE
HISTORY OF CASE

TESTS AND EXAMINATIONS
LABORATORY RESULTS

OPINION OF DEATH
REMARKS

SIGNATURE OF EXAMINER
DATE OF SIGNATURE

TESTIMONY OF WITNESSES
SIGNATURES

NOTARIAL CERTIFICATE
NOTARY PUBLIC

BUREAU V. S.

NOV 14 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11401

Reg. Dist. No. 9

11383

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

40 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

22 Frostburg

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. at Miners Hospital

d. STREET ADDRESS

208 W. Mechanic St.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Harry Edward

Middle

Last

Wolford

4. DATE
OF
DEATH

Month

Nov.

Day

29

Year

19 57

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

B. DATE OF BIRTH

May 18-1895

9. AGE (In years
last birthday)

62 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Coal operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Loganton, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Levi Wolford

14. MOTHER'S MAIDEN NAME

Tilley Lupold

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-05-7167

17. INFORMANT

Address

(son) Donald Wolford, Frostburg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Asphyxiation

INTERVAL BETWEEN
ONSET AND DEATH

about

DUE TO

891.0
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Carbon monoxide poisoning

(c)

2 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Let engine of truck run in garage while working on it.

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.
p. m.

noon Nov 29 19 57

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Garage at home

20f. (City or town)

Frostburg, Allegany

(County)

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Nov. 29-1957

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12-1-57

22c. NAME OF CEMETERY OR CREMATORY

Frostburg Memorial Park

22d. LOCATION (City, town, or county)

Frostburg, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J. R. Durst,

Frostburg, Md.

24a. REC'D BY REGISTRAR

DATE 12-2-57

24b. REGISTRAR'S SIGNATURE

Mr. Nancy H. Roe

MD STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels on the right side.

BUREAU V. 2

DEC 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11364 CERTIFICATE OF DEATH

Reg. Dist. No. 11402

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
		d. STREET ADDRESS <u>304 Decatur Street</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Viola</u> Last <u>Youts</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/88</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bucy</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Marvin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-05-1145</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma -left Ovary</u> <u>175X</u> DUE TO <u>Carcinomatosis.Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> <u>6 years</u> <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 31, 1957</u> to <u>November 18, 1957</u> that I last saw the deceased alive on <u>November 18, 1957</u> , and that death occurred at <u>6.35A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Hallinan M.D.</u>		ADDRESS (Street, city or town, state) <u>140 Bedford St., Cumberland, Md.</u> DATE SIGNED <u>11-18-57</u>	
PHYSICIAN'S NAME (Type) <u>James P. Hallinan M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee. Silcox-</u> ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 20, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Jon van Stien, M.D.</u>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. PLACE OF DEATH	
JAMES H. HARRIS		Male		45		1910		Maryland		Maryland	
7. OCCUPATION		8. MARITAL STATUS		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
Farmer		Married		Heart Disease		Natural		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. DATE OF INTERMENT		15. NAME OF CEMETERY		16. NAME OF MINISTER		17. NAME OF FUNERAL HOME		18. NAME OF UNDERTAKER	
St. James Cemetery		1925		St. James Cemetery		Rev. J. H. Harris		J. H. Harris		J. H. Harris	

315-00-1113

19. NAME OF PHYSICIAN		20. NAME OF REGISTRAR		21. NAME OF MINISTER		22. NAME OF FUNERAL HOME		23. NAME OF UNDERTAKER		24. NAME OF CEMETERY	
J. H. Harris		J. H. Harris		Rev. J. H. Harris		J. H. Harris		J. H. Harris		St. James Cemetery	
25. NAME OF PHYSICIAN		26. NAME OF REGISTRAR		27. NAME OF MINISTER		28. NAME OF FUNERAL HOME		29. NAME OF UNDERTAKER		30. NAME OF CEMETERY	
J. H. Harris		J. H. Harris		Rev. J. H. Harris		J. H. Harris		J. H. Harris		St. James Cemetery	

BUREAU V. S.

NOV 21 1925

RECEIVED

Within corporate limits

11365

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 420 Grand Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Leona Last Zimmerman		4. DATE OF DEATH Month November Day 14 , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Hoff		14. MOTHER'S MAIDEN NAME Margaret Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. INFORMANT Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Cerebral Hemorrhage DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/16/57 , 19 57 , to 11/14/57 , 19 57 , that I last saw the deceased alive on 11/13/57 , 19 57 , and that death occurred at 2:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/14/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-16-57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE 16, 1957		24b. REGISTRAR'S SIGNATURE Jon van Strien M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU A. F.

NOV 20 1957

Cum gratia

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